

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last GROVER CLEVELAND ABE						2a. DATE OF DEATH 10 Month 17 Day 68 Year			2b. HOUR P 6:45 M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/22/84			6. AGE (In years last birthday) 84-84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER Retired			12b. KIND OF BUSINESS OR INDUSTRY FARMER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.				13b. COUNTY V		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER none	
14. FATHER'S NAME First Middle Last PHILLIP ABE				15. MOTHER'S MAIDEN NAME First Middle Last ANNIE LARGENT ABE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. 234 40 3078		17. INFORMANT Address SACRED HEART HOSPITAL 900 SETON DRIVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> 141.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Squamous cell Carcinoma base of tongue</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Age -</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 141.0 Probably emphysema, arteriosclerosis, Radiation											
19a. DATE OF OPERATION RADIUM IMPT		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell Carcinoma floor of mouth			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 7-2-1968, to 10-1-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Vicente M. Valls, M.D.				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-18-68			
22d. PHYSICIAN'S NAME (Type) DR. VICENTE VALLS				22e. ADDRESS 113-A SOUTH CENTRE STREET				CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery			23d. LOCATION (City or Town) (County) (State) Near Ridgeley, W. Va.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 7-68

13701										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13712																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Mary										Middle Susan										Last Adams										October 11 1968										430PM																			
3. SEX Female										4. RACE White										5. DATE OF BIRTH 8-17-1884										6. AGE (In years last birthday) 84 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Virginia										7b. CITIZEN OF WHAT COUNTRY? America										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Alleghany										Md.																			
10. CITY OR TOWN OF DEATH Cumberland, Md.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Alleghany										13c. CITY OR TOWN Cumberland										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 308 Grand Ave.																			
14. FATHER'S NAME Albert Silas Newlon										15. MOTHER'S MAIDEN NAME Mary Frances Newlon										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO										16b. SOCIAL SECURITY NO. 220-10-7790-D										17. INFORMANT Address 2927 Penn. Ave. Daughter Lorena Thompson Washington, DC.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1519 Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Stomach 1 yr DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis 5 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from June 1966, to Oct 11, 1968, that (I) (we) last saw the deceased alive on Oct 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Clay Durrett DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 10/12/68																													
22d. PHYSICIAN'S NAME (Type) CLAY DURRETT										22e. ADDRESS 236 Va. Ave. Cumberland																																																	
23a. BURIAL, CREMATION, REMOVAL BURIAL										23b. DATE OCT 14, 1968										23c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY										23d. LOCATION (City or Town) (County) (State) WESTERNPORT ALLEGANY MARYLAND																													
24. FUNERAL DIRECTOR SILCOX-MERRITT 404 DECATUR STREET CUMBERLAND										ADDRESS										25a. REC'D BY REGISTRAR DATE OCT 15 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge																													

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) BABY			First BOY Middle ALLEN Last			2a. DATE OF DEATH Month OCTOBER Day 13 Year 1968		2b. HOUR 3:30 MIN M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCTOBER 11, 1968		6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS — DAYS — HOURS — MIN. —	
7a. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL,		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD. COUNTY ALLEGANY		13b. CITY OR TOWN CUMBERLAND		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MEMORIAL AVENUE			
14. FATHER'S NAME First DONN Middle WILLIAM Last ALLEN			15. MOTHER'S MAIDEN NAME First MRS Middle MARCIA Last ANN			15. MOTHER'S MAIDEN NAME First ANN Middle MCGUIRE Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7762 (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) 27 wks gestation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 31 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 68 , to 10/13 , 19 68 , that (I) (we) last saw the deceased alive on 10/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Dawson M.D.				DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-14-68			
22d. PHYSICIAN'S NAME (Type) DR. ROBERT DAWSON				22e. ADDRESS 500 GREENE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-13-68		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Springfield, Hamp. W.Va.			
24. FUNERAL DIRECTOR James F. Scarfelli Cumberland Md				25a. REC'D BY REGISTRAR OCT 17 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

13713

RECEIVED BY DEPT

DATE: OCTOBER 12, 1950
TIME: 10:30 AM
BY: BOY

TO: WHITE
FROM: WHITE

SUBJECT: [illegible]

RE: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2. DATE OF DEATH		2b. HOUR	
MARY		M		ARONHALT				OCTOBER 25, 1968		2:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		AUGUST 20, 1891		77 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
MT. STORM, W. VA.		U.S.A.		WIDOWED		DIVORCED		ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND		YES		442 PENNSYLVANIA AVE.,			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
CHARLES						NORRIS		HARTLEY,		ANNA E.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		None		MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u>										1 yr	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u>										3 mon	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocarditis & Decomposition</u>										2 mon	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
151X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>68</u> , to <u>Oct 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>Clay E. Durrett</u>		10/25/68		DR. CLAY E. DURRETT		236 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Oct. 28, 1968		Hillcrest Burial Park		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.				OCT 29 1968		<u>Charles Judge</u>					

James E. Neerhoff, Cumberland, Md.

OCT 29 1968

Surgeon - Oct. 28, 1968 Baltimore Medical Park, Cumberland, Md.

DR. CLAY E. DORRITT

335 VIRGINIA AVE., CUMBERLAND, MD.

NO

None

CHARLES

MORRIS

HARTLEY,

ANNA E.

MARYLAND

ALLEGHANY

CUMBERLAND X

112 PENNSYLVANIA AVE.,

CUMBERLAND

MEMORIAL HOSPITAL

ALLEGHANY

U.S.A.

112 STOR, N.Y.

WHITE

FEMALE

AUGUST 20, 1961

ARCHAET

OCTOBER 22, 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13704										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13715																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
DESSIE O. ATHEY										OCTOBER 3, 1968										8:50																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 10-17-1904										6. AGE (In years last birthday) 68 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) W.VA.										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY Md.																													
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY Own Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN CORRIGANVILLE										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER P. O. BOX 46																			
14. FATHER'S NAME First Middle Last GRANT MC DONALD										15. MOTHER'S MAIDEN NAME First Middle Last MAE SWISHER										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) 18										16b. SOCIAL SECURITY NO. 217-10-5950										17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Occlusion</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yes</u>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u> <u>Rheumatic Heart Disease</u>																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>10/4/68</u>																																							
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT										22e. ADDRESS 133 VA. AVE., CUMBERLAND, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Oct 6, 1968										23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park										23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.																													
24. FUNERAL DIRECTOR William G. Kight										ADDRESS Cumberland, Md.										25a. REC'D BY REGISTRAR DATE OCT 9 1968										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																													

13715

NOTICE OF DEATH

DECEASED: JESSIE O. WHITE

DATE OF DEATH: 10-17-1904

AGE: 40

PLACE OF BIRTH: CONNERSVILLE, INDIANA

PLACE OF DEATH: CONNERSVILLE, INDIANA

CAUSE OF DEATH: DISEASE

DATE OF BURIAL: 10-18-1904

PLACE OF BURIAL: CONNERSVILLE, INDIANA

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF INTERVIEWER: [illegible]

NAME OF WITNESS: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF INTERVIEWER: [illegible]

NAME OF WITNESS: [illegible]

NAME OF MINISTER: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove garden papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13705									
CERTIFICATE OF DEATH									
13716									
1. DECEASED-NAME (Type or print) EDITH EDNA ATHEY					2a. DATE OF DEATH Month OCTOBER Day 8 Year 1968 2b. HOUR 2:00 A M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-25-93		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS 13 IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) WEST VA Patterson Creek		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN KEYSER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 318 MAIN ST.	
14. FATHER'S NAME First DAVID ; Middle Last LEATHERMAN					15. MOTHER'S MAIDEN NAME First AGNES Middle Last EMBERSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. NO		17. INFORMANT PATIENT'S HOSP CHART SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS UNDERLYING: 4120 IMMEDIATE CAUSE (a) Nephrosclerosis and azotemia 20 years DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary disease 20 years DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of breast 1 year PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Dysphagia recording to 18c									
19a. DATE OF OPERATION 26 Sept 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dysphagia		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 24 Sept 68 , to 8 Oct 68 , that (I) (we) lost saw the deceased alive on 7 Oct 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Fred W. Miltenberger					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8 Oct 68		
22d. PHYSICIAN'S NAME (Type) F. MILTENBERGER, M.D.					22e. ADDRESS 122 S. CENTRE ST., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-11-68		23c. NAME OF CEMETERY OR CREMATORY Potomac V.M. Park		23d. LOCATION (City or Town) (County) (State) Keyser, W. Va.			
24. FUNERAL DIRECTOR Harold W. McKeage MARKWOOD FUNERAL HOME KEYSER, WEST VA.					25a. REC'D BY REGISTRAR OCT 14 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
HARRY			FRANKLIN			BANE			10 Month 3 Day 68 Year 7:45AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		4/4/07		61 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
WEST VIRGINIA			UNITED STATES				ALLEGANY CO., Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.			SACRED HEART HOSPITAL			BARBER		BARBER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			ALLEGANY		CUMBERLAND				Bowling Greene 523 MC MULLEN HWY.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
FRANK - BANE			LILY Ellen PICKENS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			217 05 0566		PATIENT'S HOSPITAL CHART				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE									1 WEEK
4129 DUE TO, OR AS A CONSEQUENCE OF CORONARY HEART DISEASE									6 MOS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5 - 13, 1959, to 10 - 3, 1968, that (I) (we) lost saw the deceased alive on 10 - 2 - 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
R. W. Ballin, M.D.								10/4/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
DR. R. W. BALLIN						62 GREENE STREET, CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/6/68		Queen's Point Cemetery		Keyser Mineral W. Va.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Wayne George Cumberland, Md.						DATE OCT 7 1968		Charles Judge	

257-2 031110 1111511 257

[illegible]

ALLEGANY COUNTY, WEST VIRGINIA

FRANK - 10/11/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
13707												
13718												
1. DECEASED NAME (Type or print) First Middle Last EMMA S. BELL						2a. DATE OF DEATH 10 Month 2 Day 68 Year			2b. HOUR 8:45 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/31/93			6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY CO., Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) UNEMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT #1, STONEYBROOK LANE			
14. FATHER'S NAME First Middle Last CARL Stiewe /STIEIVE			15. MOTHER'S MAIDEN NAME First Middle Last MATILDA Gowitzke GOWITZKY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 291 01 7103		17. INFORMANT PATIENT'S HOSPITAL CHART Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 153.8 DUE TO, OR AS A CONSEQUENCE OF (b) <u>anemia; hypoproteinemia, diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic metastasis -> carcinoma of colon</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 153.8 <u>myocardial fibrosis and cardiomegaly</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION JAN - 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF COLON			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 21, 1968</u> , to <u>OCT 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Richard Schindler M.D.						22c. DATE SIGNED OCT 3 - 1968		22d. PHYSICIAN'S NAME (Type) DR. RICHARD SCHINDLER				
22e. ADDRESS 69 GREENE ST., CUMBERLAND, MD. 21502												
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Oct. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY L. Beinhauer & Son Co.			23d. LOCATION (City or Town) (County) (State) Pittsburgh Allegheny, Penna.					
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave. Cumb., Md.						25a. REC'D BY REGISTRAR OCT 7 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge				

13718

10	CARL	STELINE	1/1/10	10.1.5.1
	LOVELAND	ALLEGANY	LA WOLF	X RT 41, STONEBROOK TONE
	OHIO	UNITED STATES	X	ALLEGANY CO.,
	FEMALE	WHITE	12.1.1.3	24
2.1	BELL	10	2	8.1.2

CHURCHMAN, ID. SACRED HEART HOSPITAL UNEMPLOYED

201 01 2103 PATIENT'S HOSPITAL CHART

DR. RICHARD SCHILLER

201 01 2103 PATIENT'S HOSPITAL CHART

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15-14
30M REV. 5-68

13708

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13719

1. DECEASED-NAME (Type or print) First Middle Lost MARGARET CECILIA BERG			2a. DATE OF DEATH 10 Month 3 Day 68 Year		2b. HOUR 4:45A
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH 10/5/19		6. AGE (In years at birthday) 48 YRS.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY CO., Md.
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER BOX 562, BOWMAN'S ADDITION
14. FATHER'S NAME First Middle Lost WILLIAM C. WEISENMILLER			15. MOTHER'S MAIDEN NAME First Middle Lost LORETTA JONES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217 18 4290		17. INFORMANT PATIENT'S HOSPITAL CHART Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 1 year 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 bronchial asthma pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10-1, 1968 , to 10-3, 1968 , that (I) (we) last saw the deceased alive on 10-2-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. Brings				22c. DATE SIGNED 10-3-68	
22d. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS				22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/6/68		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 7 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

13709		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13720	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First Middle Last BLACKA Leot C. LEOT Blacka C		2a. DATE OF DEATH OCTOBER 7, 1968	
3. SEX FEMALE		4. RACE WHITE		2b. HOUR 4:15 PM	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (In years last birthday) 74 YRS.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) MEMORIAL HOSPITAL		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		9. COUNTY OF DEATH ALLEGANY	
13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE	
13e. STREET AND NUMBER 219 GRAND AVE.		12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME First Middle Last HENRY BROWN		15. MOTHER'S MAIDEN NAME First Middle Last JENNIE DUNAWAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMB. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, pancreas a bleeding tree</i> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>Possibly 1 yr.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1578					
19a. DATE OF OPERATION 10-4-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma - pancreas</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-21</i> , 19 <i>68</i> , to <i>10-7</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>10-7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Carlton Brinsfield</i>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) DR. XXXXXXXXXX	
22e. ADDRESS CUMBERLAND, MD.		22f. ADDRESS CUMBERLAND, MD.		22g. DATE SIGNED OCT 18 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-10-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		23e. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		23f. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Searpelli, Cumberland, Md.		24a. ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24c. DATE OCT 18 1968		24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		24e. DATE OCT 18 1968	

James V. Gurnea, Jr., Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

13710

13721

1. DECEASED-NAME (Type or print)			First	Middle	Lost	20. DATE OF DEATH			2b. HOUR P			
HELEN CATHERINE BOCKHOUSE						10	Month	7	Day	68	Year	5:10 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
FEMALE		WHITE		3 11 08		60 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		USA				ALLEGANY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND		SACRED HEART HOSPITAL		SECRETARIAL Duties		Automotive Parts						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MD.		ALLEGANY		LaVale,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1055 NATIONAL HIGHWAY				
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost	
HENRY						BERTHA			DAVIS			
16a. WAS DECEASED EVER Yes, no, or NO (own)		IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
NO						HOSPITAL RECORDS		900 SETON DRIVE -CUMBERLAND				
								MARYLAND 21502		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Corbary Pulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of left Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lung & Mediastinal Metastasis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2, 1968</u> , to <u>10/2, 1968</u> , that (I) (we) lost saw the deceased alive on <u>10/2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DATE SIGNED				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
		10/8/68										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
DR. J. A. PAGAN		LA VALE, MARYLAND 21502										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		10/10/68		St. Luke's Cemetery		Cumberland		Allegany		Md.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
H. Wayne George		Cumberland, Md.				DATE		OCT 14 1968				

15732

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED OCTOBER 10 1964

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-388610)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [REDACTED]

RE: [REDACTED]
DATE: [REDACTED]
BY: [REDACTED]

[REDACTED]

100-100000-1000

100-100000-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13711

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13722

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
Ethel				Albino	Bone	October 16 1968			3:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		May 25, 1892			76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.		
West Virginia		U S A		Cumberland, Md			Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		802 Stewart Ave.		Housewife							
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Allegany		Cumberland				802 Stewart Avenue			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
John			J.	Doyle		Harriet			E.	Ellis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mr. Jesse M. Bone, 802 Stewart Ave.			Cumberland, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic cysto-pyelitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>4221</u> Chronic cysto-pyelitis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5 - 2, 19 63</u> , to <u>10 - 16, 19 68</u> , that (I) (we) last saw the deceased alive on <u>10 - 16, 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ralph W. Ballin</u>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-17-68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Ralph W. Ballin, M.D.		62 Greene St. Cumberland, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		10/19/1968		Hillcrest Burial Park				Near Cumberland, Alleg Md			
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>		ADDRESS		Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles E. Hafer, 230 Balto Ave., Cumberland						OCT 18 1968		<u>Charles Judge</u>			

1872

John T. Kelly, 1000 1st Ave., New York, N.Y.

John T. Kelly, 1000 1st Ave., New York, N.Y.

John T. Kelly, 1000 1st Ave., New York, N.Y.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last MILLARD F. BOWMAN					Month Day Year 10-01-68			11:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		09-24-90		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL				CELANESE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				RT. #5, CUMB., MD.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
MECHEAL BOWMAN			(DEIST) CLARA BOWMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO			214-07-1919A		900 SETON DR. ADDRESS HOSPITAL RECORDS - CUMBERLAND, MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>2 years</u> <u>4 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-3-</u> , 19 <u>68</u> , to <u>10-1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Brings</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-2-68</u>		
22d. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.					22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10/4/1968		SALISBURY-I.O.O.F.		SALISBURY-SOMERSET-CD-PA			
24. FUNERAL DIRECTOR <u>Stanley M. Thomas</u>					25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
THOMAS FUNERAL HOME, SALISBURY, PENNSYLVANIA									

THOMAS EUGENE HOLT, SOLISBURY, PENNSYLVANIA

LEWIS BRIDGES, W.D.

27 GREENE ST., CORNER W. 51ST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANNA		First I.	Middle	Last BROTEMARKLE	2a. DATE OF DEATH Month OCTOBER Day 8 , 19 68		2b. HOUR 7:45 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7-15-94		6. AGE (In years lost 57 74) YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PA.		13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME CHARLES		First	Middle	Last LOGSDON	15. MOTHER'S MAIDEN NAME MARGARET C. LOWERY		First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 210-18-9511		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, endometrial with metastasis 1820 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 172 X											
19a. DATE OF OPERATION 9-11-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 1 , 19 66 , to 10-8 , 19 68 , that (I) (we) last saw the deceased alive on 10-8 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlton Brinsfield MD		DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-12-68				
22d. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD		22e. ADDRESS 401 DECATUR ST., CUMB. MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City or Town) Hyndman, Bedford Co., Pa.		(County)		(State)	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.					25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

18724

UNITED STATES OF AMERICA

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U. S. A. 17-12-50

U. S. A. 17-12-50

U. S. A. 17-12-50

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13714

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13725

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR			
Samuel			Frantz			Carl			OF ESTI- DEATH MATED <input type="checkbox"/> 10 11 1968 8 A M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR	
Male	White	12/14/1914	53 YRS.					10 11 1968			9 A M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
Maryland		U.S.A.					Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland			D.O.A.- Sacred Heart Hosp			Cumb News Telegraph Editor.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Allegany		LaVale				951 National Highway			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Urner G			Carl			Kathryn			Frantz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No			214-05-4895		Margaret J. Carl			951 National Hwy LaVale, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22b. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 11, 1968 ADDRESS (Street, city, town, or county) Cumberland, Maryland										
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial		10/13/68		Rest Lawn Mem Gardens				LaVale Allegany Maryland				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. Lee Silcox				Cumberland, Maryland 21502				DATE OCT 15 1968		J Charles Judge		

13735

WITNESS TO THE SIGNATURE OF THE

TO THE HONORABLE SECRETARY OF THE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13726

1. DECEASED-NAME (Type or Print)			First James			Middle Arthur			Last Carr			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 10-22-68			2b. HOUR 5:45 PM								
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 8, 1912		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year OCTOBER 22, 1968			2d. HOUR 5:45 AM								
7a. BIRTHPLACE (State or foreign country) W. Va.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.											
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Factory worker				12b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.				13b. COUNTY Mineral				13c. CITY OR TOWN Ridgeley,				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 153 Main St.									
14. FATHER'S NAME			First Saul			Middle --			Last Carr			15. MOTHER'S MAIDEN NAME			First Stella			Middle --			Last White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 236-12-9530				17. INFORMANT Mrs. Elmer J. Kalbaugh,				ADDRESS W. Va. 153 Main St. Ridgeley							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED											
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> OCTOBER 22, 1968											
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 10/24/68				23c. NAME OF CEMETERY OR CREMATORY Mt. State Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Elkins, Randolph, W. Va.											
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland										25a. REC'D BY REGISTRAR DATE OCT 25 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge									



100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH		2b. HOUR	
Edgar Raymond Chase						Month Day Year		10-18-68 19 6:58pM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	Oct. 1, 1901	67 YRS.	MONTHS	DAYS	HOURS	MIN.	October 18, 1968 19 6:58pM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Cumberland, Md.		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Memorial Hospital			Retired Carman		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Allegany		Cumberland				118 Bedford St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Harry E. Chase			Annie Hobrock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			705-05-4564		Mrs. Gracie Chase, Cumberland, Md. Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage									8 Days
4120 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardiovascular disease									--
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
443X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. P.M.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarellic						October 18, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
BENEDICT SKITARELIC, M.D.			CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 21, 1968		Hillcrest Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				DATE		OCT 22 1968			

23737

10-10-68 6:50p 10-10-68 6:50p

Male white Cat. I, 1901 25 10-10-68 6:50p

Cambridge, No. USA Albany

Cambridge Memorial Hospital 10-10-68 6:50p

Mr. Alagna Cambridge 10-10-68 6:50p

Harry E. Chase 10-10-68 6:50p

10-10-68 6:50p Mrs. Grace Chase, Cambridge, Md. Wife

General Hospital 10-10-68 6:50p

Hypertensive Cardiovascular disease --

X

XX

X October 10, 1968

CAMBRIDGE, MASSACHUSETTS

Cambridge, Mass. 10-10-68

10-10-68

10-10-68 6:50p

10-10-68 6:50p

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13717										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13728																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
Robert Augustus Clarke										October 30 1968																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										White										October 23, 1893										75 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Newfoundland										Canada																				Allegany										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Cumberland										1819 Bedford Road										Retired Sea Captain										Canadian M																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER										Merchant Marine									
Maryland										Allegany										Cumberland										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1819 Bedford Road																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Robert Clarke										Mary Ann Clarke																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address										Md.																			
Yes										WW 1										220-44-6324										Mrs. Paul Castelle, 401 LeFevre Rd.										Cumberland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY:																														10 days																													
IMMEDIATE CAUSE (a)										Renal Failure																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Far Advanced Carcinoma of Prostate																				-Yrs -																													
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 3/2/68, to 10/30/68, that (I) (we) last saw the deceased alive on 10/30/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Walter N. Hummel										11/2/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										412 N. Mechanic St.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Cremation										11/2/1968										Homewood Crematorium										Pittsburgh Allegheny Penna.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
John J. Hefer, Jr.										230 Balto Ave. Cumberland										NOV 6 1968										J. Charles Judge																													

13758

GENERAL OF THE

THE UNITED STATES OF AMERICA

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13718

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13729

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH			2b. HOUR		
Oscar Herbert Clauson						Month Day Year			10-18-68 19 6:30p M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Mar. 7, 1898	70 YRS.	MONTHS	DAYS	HOURS	MIN.	October 18, 1968			19 6:30p M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital			Iron worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Allegany			Corriganville					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Lost			First Middle Lost		
John Clauson			Clara (Knepp) Clauson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			1917-1919			207-09-6528 John L. Clauson, Corriganville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812.9</u> DUE TO, OR AS A CONSEQUENCE OF PULMONARY EMBOLISM, MASSIVE CRUSHING INJURIES OF BOTH KNEES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 5 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>816.4</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			8:00 P.M. 10-13-68			Automobile collision Rt. #35, 2 miles west of Corriganville, Md.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
			Rt. # 35			Rt. #35, 2 miles west of Corriganville, Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			OCTOBER 18, 1968		
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			October 21, 1968			Rose Hill Cemetery			Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Harvey H. Zeigler, Hyndman, Pa.									25b. REGISTRAR'S SIGNATURE		
						DATE			OCT 22 1968		

13758

RECORDS SECTION, U.S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 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636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 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886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

13719										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13730									
1. DECEASED-NAME (Type or print) First Middle Last ELEANOR V COGLAN										2a. DATE OF DEATH Month Day Year OCTOBER 1 1968										2b. HOUR 2:15 PM									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH 5-24-01					6. AGE (In years last birthday) 67 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) WESTERNPORT, MD.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHING					12b. KIND OF BUSINESS OR INDUSTRY TEACHER														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.					13b. COUNTY ALLEGANY					13c. CITY OR TOWN WESTERNPORT					13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 131 PHILOS AVE.,									
14. FATHER'S NAME First Middle Last ALLAN COGLAN					15. MOTHER'S MAIDEN NAME First Middle Last MARY ELLEN MARTIN																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No					16b. SOCIAL SECURITY NO. 212-38-7328					17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longstanding heart failure on</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>basal of a for advanced A.D.P. U.A.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-3-</u> 19 <u>68</u> , to <u>10-1-</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-30-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Wm. F. Williams</u>					22c. DATE SIGNED 10-1-68																								
22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS					22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Oct. 3, 1968					23c. NAME OF CEMETERY OR CREMATORY Philos					23d. LOCATION (City or Town) (County) (State) Westernport Allegany Md														
24. FUNERAL DIRECTOR Fredlock					25a. REC'D BY REGISTRAR DATE OCT 7 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			

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THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First JOHN			Middle RAY		Last CONDON		2a. DATE OF DEATH Month 10 Day 7 Year 68	2b. HOUR 12:25 P M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-14-66			6. AGE (In years last birthday) 2 YRS.		IF UNDER 1 YEAR MONTHS 2 DAYS 23		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VIRGINIA		13b. COUNTY Mineral		13c. CITY OR TOWN KEYSER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 129 CARROLL AVENUE			
14. FATHER'S NAME First RAYMOND Middle E. Last CONDON			15. MOTHER'S MAIDEN NAME First HELEN Middle M. Last MILLER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Respiratory Failure											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Central Nervous System Damage 8 days											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Dehydration + Acidosis 8-10 days.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 355X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9-29- , 19 68 , to 10-7-68 , 19 68 , that (I) (we) last saw the deceased alive on 10-7- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert D. Brodell						22c. DATE SIGNED 10-8-68		22d. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL			
22e. ADDRESS CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-11-68		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		23d. LOCATION (City or Town) (County) (State) Keyser, W. Va. (Mineral)					
24. FUNERAL DIRECTOR Harold W. McConz						25a. REC'D BY REGISTRAR Keyser, W. Va.		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
DATE OCT 14 1968											

MEDICAL CERTIFICATION

13731

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CORPORAL

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MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

12 CARROLL AVENUE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR 151
30M REV. 1-68

13721										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13732			
1. DECEASED-NAME (Type or print) First Middle Last EMIL ELLSWORTH CROWE										2a. DATE OF DEATH 10 Month 27 Day 68 Year										2b. HOUR 12:15 PM			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 1 5 98					6. AGE (In years last birthday) 78 YRS.					IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.												
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEXTILE					12b. KIND OF BUSINESS OR INDUSTRY TEXTILE										
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. CITY OR TOWN ALLEGANY			13c. CITY OR TOWN LONA CONING			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER UNION STREET												
14. FATHER'S NAME First Middle Last EMIL E. CROWE					15. MOTHER'S MAIDEN NAME First Middle Last MARGARET TEESDALE CROWE																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220 10 1233			17. INFORMANT Address SACRED HEART HOSPITAL 900 SETON DRIVE																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Lungs</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										CUMBERLAND, MD. 21502 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs ???													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163 X Esophageal Stricture -																							
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ✓																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓			21f. LOCATION Street or R.F.D.-No. City or Town County State ✓																	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>68</u> , to <u>10-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Martin M. Rothstein MD</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10-28-68														
22d. PHYSICIAN'S NAME (Type) DR. MARTIN M. ROTHSTEIN			22e. ADDRESS 48 BROADWAY ST -CUMBERLAND, MD.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/29/68			23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Lonaconing A. Md														
24. FUNERAL DIRECTOR George Eichhorn			ADDRESS Lonaconing, Md			25a. REC'D BY REGISTRAR DATE OCT 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge														

21:51

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BME-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
HARRIETT V. DAWSON						10/11 1968			11 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
FEMALE	WHITE	OCT. 1, 1871	97 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			11 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
VIRGINIA			USA				ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			ROUTE 6			HOUSEWIFE			OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY CUMBERLAND					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		BOX 309, ROUTE 6,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FREDERICK KYLES			LETTIE SNYDER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			NONE			MRS. G. A. CAPEL			RT. 6, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE										MONTHS	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										YEARS	
(b) ADVANCED ARTERIOSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				OCT. 11, 1968			
				RT. 9, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			10/14/68			PHILOS CEMETERY			WESTERNPORT, MD.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
BYRON KIGHT						CUMBERLAND, MD.			DATE OCT 21 1968		
									25b. REGISTRAR'S SIGNATURE		
									J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13723 CERTIFICATE OF DEATH 13734									
1. DECEASED-NAME (Type or print)		First MIDDLE Last CHARLES B. DIEHL		2a. DATE OF DEATH Month Day Year OCTOBER 31, 1968		2b. HOUR PM 8:40			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-6-04		6. AGE (In years last birthday) 64		YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ELECTRIC		12b. KIND OF BUSINESS OR INDUSTRY ELECTRIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND		13b. CITY OR TOWN ALLEGANY CORRIANVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First MIDDLE Last CHARLES E. DIEHL		15. MOTHER'S MAIDEN NAME First MIDDLE Last JENNIE SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-07-0290		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma stomach & metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 151X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gastric Carcinoma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-19-68, 1968</u> , to <u>10-31-1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Carroll Brinsfield</u>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) C. BRINSFIELD		22e. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.				25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13722

CHARLES E. WIGHT
MALE
WHITE
1-2-38
MARYLAND
U. S. A.
ALLEGANY
CUMBERLAND
HOSPITAL
ALLEGANY CORRIDORVILLE
CHARLES E. WIGHT
MALE
WHITE
1-2-38
MARYLAND
U. S. A.
ALLEGANY
CUMBERLAND
HOSPITAL
ALLEGANY CORRIDORVILLE

C. BRINSFIELD
CUMBERLAND, MD.

NOV 1 1938

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13724

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13735

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR		
STANLEY LEO DONAHOE, JR.						10-14-68			1968			12:00a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
MALE	WHITE	MAY 24, 1930	38 YRS.					October 14, 1968			12:30a M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH					
MARYLAND			USA						ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND			ROUTE 5			NONE								
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
MARYLAND			ALLEGANY CUMBERLAND						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ROUTE 5		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
STANLEY LEO DONAHOE, SR.			LEAH KNEE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
YES			KOREAN WAR			218 30 0347			LEAH DONAHOE, ROUTE 5, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF 5319 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ULCERATION OF GASTRIC MUCOSA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 HOURS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5400														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			October 14, 1968					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			CUMBERLAND, MARYLAND					
						ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			OCT. 17, 1968			HILLCREST BURIAL PARK			CUMBERLAND, MD.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
BYRON KIGHT			CUMBERLAND, MD.			DATE OCT 21 1968			J. Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First CHARLES		Middle F.		Last ENGLE		2a. DATE OF DEATH Month Day Year OCT. 20 1968			2b. HOUR 9:15 P.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 21, 1876			6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STONE MASON			12b. KIND OF BUSINESS OR INDUSTRY SELF		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 62 ASPINALL STREET		
14. FATHER'S NAME First Middle Last HENRY ENGLE				15. MOTHER'S MAIDEN NAME First Middle Last CAROLINE HETRICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-05-7654		17. INFORMANT Address MRS. DORCAS CROWE, FROSTBURG, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD.</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>advanced age</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>10 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4201</u>											
19a. DATE OF OPERATION <u>✓</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>✓</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>✓</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>✓</u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>✓</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>✓</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>68</u> , to <u>10-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Martin Rothstein</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-31-68</u>			
22d. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.						22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY ZION EVAN. LUTHERAN			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13338

REPUBLIC OF CHINA

THE NATIONAL GOVERNMENT OF THE REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13726										
CERTIFICATE OF DEATH										
13737										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Lillian M. Ewan						Oct. 10 Day 1968			9: M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years birth day)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		May 25, 1894		74 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			9 Boone St.			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.			Allegany			Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
9 Boone St.			First Middle Last			First Middle Last				
			William F. Hammers			Bridget O'Brien				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
no						Mrs. Marcus Naughton, Cumberland, Md.			Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Chronic Myocarditis (b) <u>Chronic Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis (c) <u>Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>3 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 1965</u> , to <u>Oct 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Clay E. Durrett</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 11, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, MD					22e. ADDRESS 236 Virginia Ave., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Oct. 14, 1968		Norland Cemetery		Chambersburg, Penna.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
					OCT 14 1968					

1973

1973

Ref.	Full Name	Birth Date	Birth Place	Gender	Marital Status	Current Address	Previous Address
1	William F. Bennett	May 22, 1924	USA	Male	Married	2 Boone St., Chamberland, Md.	2 Boone St., Chamberland, Md.
2	William F. Bennett	May 22, 1924	USA	Male	Married	2 Boone St., Chamberland, Md.	2 Boone St., Chamberland, Md.
3	William F. Bennett	May 22, 1924	USA	Male	Married	2 Boone St., Chamberland, Md.	2 Boone St., Chamberland, Md.

Dr. Gray B. Bennett, MD
236 Virginia Ave.,
Chamberland, Md.

Detail Oct. 14, 1968
James E. Campbell, Chamberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13727					13738					
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Lost		2a. DATE OF DEATH			2b. HOUR		
CLEMENT JOHN FESTERMAN					10 Month 11 Day 68 Year			4:10PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
MALE		WHITE		8-13-10		58 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSPITAL			CLEANERS		TEXTILE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		220 UPPER CONSOL ROAD	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost							
JOHN FESTERMAN			LLOYD ANNIE FESTERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO			214-07-6917		SACRED HEART HOSPITAL CUMBERLAND, MD.		900 SETON DRIVE, 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>								months		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>								week		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5810										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1968</u> to <u>Oct 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Blane M. Schindler</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/13/68</u>			
22d. PHYSICIAN'S NAME (Type) DR. BLANE M. SCHINDLER					22e. ADDRESS 43 GREENE STREET, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		OCT. 14 '68		F.B.G. MEMORIAL PARK		FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532					25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

2553

1994

13728

CERTIFICATE OF DEATH

13739

1. DECEASED NAME (Type or print) ETHEL FLORENCE FLANAGAN			2a. DATE OF DEATH 10 Month 10 Day 68 Year			2b. HOUR P 9:00M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10 2 04		6. AGE (In years last birthday) 64 YRS.			
7a. BIRTHPLACE (State or foreign country) W. VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First SAMUEL Middle LANDIS Last LANDIS			15. MOTHER'S MAIDEN NAME First MINNIE (WISE) Middle LANDIS Last LANDIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (if known) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212 24 2159		17. INFORMANT Address SACRED HEART HOSPITAL 900 SETON DRIVE, CUMBERLAND, MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF, arteriosclerotic heart disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 6 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1966, to 10/10/1968, that (I) (we) last saw the deceased alive on 10/10/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. J. A. PAGAN				22c. DATE SIGNED 10/12/68		22d. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN			
22e. ADDRESS LA VALE, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/14/1968		Frostburg Memorial Park		Frostburg Alleg Md.			
24. FUNERAL DIRECTOR John J. Hafer, Jr., 230 Balto Ave. Cumberland				25a. REC'D BY REGISTRAR DATE 10 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

558

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RME-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages Page 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13729

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13740

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR	
William Robert Folk						MATED <input checked="" type="checkbox"/> <input type="checkbox"/>			Oct. 20, 1968			8:30 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	White	Oct. 20, 1912	56 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			8:30 A.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland,			Sacred Heart Hosp.			Nite watchman			City of Cumb.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Allegany		Cumberland,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		518 Pearre Ave.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Charles K. Folk			Cecelia -- Rawlings										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
Yes			W. W. # 2		Mrs. M. Elizabeth Folk, 518 Pearre Ave. Cumb. Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												Sudden	
IMMEDIATE CAUSE (a) coronary occlusion													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) coronary thrombosis												"	
DUE TO, OR AS A CONSEQUENCE OF													
(c) coronary sclerosis												---	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201 hypertensive cardiovascular disease													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)				Benedict Skitarelic, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				Oct. 20, 1968	
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Rt. # 9 Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				10/22/68		Hillcrest Burial Park, Cumberland, Allegany Maryland							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H. Wayne George				Cumberland, Maryland				DATE OCT 22 1968		J. Charles Judge			

25731

02735

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
ROBERT R. FOOTE						10 Month 23 Day 68 Year			11:20						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
MALE		WHITE		8 28 01			67 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
MARYLAND			USA						ALLEGANY			Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND				SACRED HEART HOSPITAL				TEXTILE				TEXTILE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND				ALLEGANY		LONA CONING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5 WATERCLIFFE STREET					
14. FATHER'S NAME				First Middle Last		15. MOTHER'S MAIDEN NAME				First Middle Last					
WILLIAM				FOOTE		KATHERINE DOYLE FOOTE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
NO						217 05 8759		SACRED HEART HOSPITAL 900 SETON DRIVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										CUMBERLAND, MARYLAND		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
510x										Pulmonary Embolism		3 WKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
518x															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-4, 1968, to 10-23, 1968, that (I) (we) lost the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
DR. WAYNE SPIGGLE												10-25-68			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS							
								912 SETON DRIVE -CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REBURYAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				1/26/68		Oak Hill Cemetery				Lonaconing A. Md					
24. FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George Eichhorn Lonaconing, Md.								DATE		OCT 28 1968					

10001

ROBERT

FOOTE

10

23

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11:2

MALE

WHITE

10 2 01

07

MARYLAND

USA

ALLEGANY

CUNBERTLAND

SACRED HEART HOSPITAL

TEXTILE

TEXTILE

MARYLAND

ALLEGANY LONACONING

X

2 WATERCLIFF STREET

WILLIAM

FOOTE

KATHERINE OXLEY FOOTE

10

217 05 250

SACRED HEART HOSPITAL 200 SECH DRIVE
CUNBERTLAND, MARYLAND

DR. WAYNE STIGGLE

212 SECH DRIVE - CUNBERTLAND, MD

OCT 2 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type of name) 13731 Hamilton Dice Friddle			2a. DATE OF DEATH Month October Day 5 Year 1968			2b. HOUR 7:50 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 27, 1881		6. AGE (in years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER B ox 406	
14. FATHER'S NAME First Middle Last John Franklin Friddle			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Doman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 220-52-9949		17. INFORMANT Alma B owman		Address B ox 406, Mt. Savage, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 403X Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Urinary Tract Infection										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 , 19 68 , to Oct. 5 , 19 68 , that (I) (we) last saw the deceased alive on Oct. 4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. Paige Strong					DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/5/68			
22d. PHYSICIAN'S NAME (Type) A. Paige Strong, M.D.					22e. ADDRESS 167 E. Main St., Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/68		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery			23d. LOCATION (City or Town) (County) (State) Romney, Hampshire, W. Va.			
24. FUNERAL DIRECTOR Wade H. McKee					ADDRESS Augusta, W. Va.		25a. REC'D BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF OHIO

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "STATE" and "OHIO" are visible.]

C. Lang Strong

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13732		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13743			
1. DECEASED-NAME (Type or print) First Middle Last ELIZABETH M. FULLER						2a. DATE OF DEATH Month Day Year OCTOBER 14, 1968		2b. HOUR:MIN 3:10 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-2-1893		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 134 OAK ST	
14. FATHER'S NAME First Middle Last THEODORE TROXELL		15. MOTHER'S MAIDEN NAME First Middle Last JAMIMA ROBINETTE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Penetrating Wound to Peritoneum</u> 428X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocarditis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 63 days 5 yrs 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 14, 1968</u> to <u>Oct 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 14, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clay E. Durrett</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>Oct. 17, 1968</u>	
22d. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT				22e. ADDRESS 236 VA. AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
13733		CERTIFICATE OF DEATH						13744			
1. DECEASED-NAME (Type or print)			First ELMER			Middle GLENN			Last GREEN		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 05-18-13			2a. DATE OF DEATH Month 10 Day 29 Year 68		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY CONTRACTING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY Garrett			13c. CITY OR TOWN GRANTSVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First GILBERT			Middle T.			Last GREEN			15. MOTHER'S MAIDEN NAME First ANNA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Mrs. Naomi Green, Grantsville, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hrs ? ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>68</u> , to <u>10/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			22c. DATE SIGNED 10/30/68			22d. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN			22e. ADDRESS LA VALE, MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/1/68			23c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.			23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.		
24. FUNERAL DIRECTOR <u>Ruth Newman</u> NEWMAN FUNERAL HOME, GRANTSVILLE, MD. 21536						25a. REC'D BY REGISTRAR DATE NOV 8 1968			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

ELMER	CLENN	GREEN	10 29 00 10:32
MALE	WHITE	05-18-13	22
MARYLAND	U.S.A.	X	WATERMAN COUNTY,
CUMBERLAND	SACRED HEART HOSPITAL	ENGINEER	CONNECTING
MARYLAND	CRANTSVILLE	X	RT. 42, CRANTSVILLE, MD.
GILBERT	T.	GREEN	(MILLER) JIMM
		GREEN	

LA VALE, MARYLAND 21502

R. J. V. BOGAN

NEWMAN FUNERAL HOME, CRANTSVILLE, MD. 21536

NOV 2 1968

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13734		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13745	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last Dorothy Mae Greene			2a. DATE OF DEATH at 7:45 P.M. Month Day Year October 26, 1968		2b. HOUR P. M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 25, 1896		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Allegany County		Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Railroad	
12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 122 Bedford Street			
14. FATHER'S NAME First Middle Last Maynard Childs			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Squibbs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No		16b. SOCIAL SECURITY NO. 215-14-6393		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Insufficiency</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chr. ASAD - Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior-Debris</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>approx. 4 days</u> <u>many years</u> <u>many years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypothyroidism - Chr. Right Hip, PT = Depression, Chr.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1964</u> to <u>Oct. 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John A. Topper</u>		DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-28-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>John A. Topper</u>		22e. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>10/29/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>S. Mary's Cem.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Cumberland</u> <u>Al</u> <u>Md.</u>					
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md.</u>		ADDRESS <u>Cumb. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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13748

DATE	NAME	ADDRESS	CITY	STATE	ZIP
MAY 22, 1963	White	1111	NEW YORK	N.Y.	10018

RECEIVED
 MAY 22 1963
 NEW YORK, N.Y.
 10018

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13735

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13746

1. DECEASED-NAME (Type or Print)		First Rebecca	Middle Jane	Last Grogg	2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year Oct. 27 1968			2b. HOUR 11:40 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 24, 1887		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year October 27, 1968		2d. HOUR 11:30 AM
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			Md.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 48 Humbird St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 48 Humbird St.	
14. FATHER'S NAME First Middle Last Isaac Graham				15. MOTHER'S MAIDEN NAME First Middle Last Martha ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Daughter Mrs. Evelyn Flanagan, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 1560 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Gall Bladder DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Months 1 Year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) 1551									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		XX October 27, 1968			
				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Bier Cemetery		23d. LOCATION (City or Town) (County) (State) Near Rawlings, Md.			
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

James L. Campbell, Cumberland, Md.

Burial Oct. 30, 1968 Star Cemetery

BENEDICT ELLIOTT, M.D.

XX October 29, 1968
CUMBERLAND, MARYLAND

Heart Laid to Rest, Md.

OCT 29 1968

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13736

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13747

1. DECEASED-NAME (Type or Print)		First Harry		Middle Burton		Last Grove		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> OCT. 31, 1968			2b. HOUR 7:45a M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 13, 1897		6. AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year 1968 OCTOBER 31, 1968		2d. HOUR 7:45a M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital				12a. USUAL OCCUPATION (Kind of work done during past working life, even if retired.) Janitor			12b. KIND OF BUSINESS OR INDUSTRY Paper Mill			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 415 Spruce				
14. FATHER'S NAME First Aden Middle _____ Last Grove				15. MOTHER'S MAIDEN NAME First Ida Middle Kookan Last _____								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. W.W.1 216-05-6195		17. INFORMANT Thomas Grove, Westernport, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, massive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4450 (b) Gangrene of feet DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Months ---		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4501												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED October 31, 1968		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ADDRESS (Street, city, town, or county) Cumberland, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/68		23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Mem. Gardens				23d. LOCATION (City or Town) (County) (State) Keyser, mineral-W. Va.				
24. FUNERAL DIRECTOR E. J. Boral				ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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MINUTE EXAMINATION REPORT

DATE

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IT WAS FOUND THAT THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-14-68
30M REV. 1-68

MEDICAL CERTIFICATION

13737										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13748														
1. DECEASED-NAME (Type or print) First Middle Last ELLA G. GUMP										2a. DATE OF DEATH Month Day Year OCTOBER 21 1968										2b. HOUR 6 P M														
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH JAN. 29, 1901					6. AGE (In years last birthday) 67 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) W. VA.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.																			
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 CARTMELL AVE.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESWOMAN					12b. KIND OF BUSINESS OR INDUSTRY INSURANCE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY ALLEGANY					13c. CITY OR TOWN CUMBERLAND					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 11 CARTMELL AVE.														
14. FATHER'S NAME First Middle Last JAMES GRUBB					15. MOTHER'S MAIDEN NAME First Middle Last ETTA DAWSON					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO. 218 30 0382					17. INFORMANT Address LYNDON M. GUMP CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years															PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from 9 - 29, 1949, to 10 - 21, 1968, that (I) (we) last saw the deceased alive on 10 - 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE Ralph W. Ballin, M.D.										DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 10-23-68														
22d. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.										22e. ADDRESS 62 GREENE ST. CUMBERLAND, MD.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE OCT. 24, 1968					23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK					23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.																			
24. FUNERAL DIRECTOR BYRON KIGHT										ADDRESS CUMBERLAND, MD.					25a. REC'D BY REGISTRAR OCT 25 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV. 1/68

13738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13749

1. DECEASED-NAME (Type or print)		First BLANCHE	Middle T.	Last HAST	2a. DATE OF DEATH Month 10 Day 19 Year 68		2b. HOUR 2:15P
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-14-87		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First JOHN		Last BAER		15. MOTHER'S MAIDEN NAME First ANNIE		Last LORDITCH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 General arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 334 x Hypertensive disease of kidney							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/12/68 , to 10/17/68 , that (I) (we) last saw the deceased alive on 10/12/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22c. DATE SIGNED 10/20/68			
22e. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/22/68		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

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END PAGE

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CERTIFICATE OF DEATH

13750

1. DECEASED-NAME (Type or print) Annie Pearl Holler			2a. DATE OF DEATH Month 11 Day 1968			2b. HOUR 4:25 MIN M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 4, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 208 Springdale St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 208 Springdale St.	
14. FATHER'S NAME First John W. Middle Stouffer Last Stouffer			15. MOTHER'S MAIDEN NAME First Mary Middle Wolford Last Wolford								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Daughter Mrs. Thelma Holler Walker, Cumberland, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Disease 437.9 DUE TO, OR AS A CONSEQUENCE OF (b) Heart Sclerotic DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 1 yr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 334x											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) —						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —			21f. LOCATION Street or R.F.D. No. City or Town County State —						
22a. I certify that (I) (this hospital) attended the deceased from 6/12/68 , 19 19 , to 10/11/68 , 19 19 , that (I) (we) last saw the deceased alive on 10/10/68 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Richard J. Williams MD					22c. DATE SIGNED Oct. 11, 1968		22d. PHYSICIAN'S NAME (Type) Dr. Richard J. Williams MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery			23d. LOCATION (City or Town) (County) (State) Madley, Penna.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
13740					13751							
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
MYRTLE			M.		HOSE				10 Month 16 Day 68 Year		7:20 ^M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE			WHITE			4-26-19			49 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
MARYLAND			USA						ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
STATE MARYLAND			ALLEGANY			OLDTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
HANSON			SLIDER						MYRTLE TWIGG SLIDER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO						SACRED HEART HOSPITAL			900 SETON DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concurrent Heart Failure</u>										3 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Embolism</u>										3 days		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>marked obesity</u>										year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
287X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 9:14, 1968, to 10:16, 1968, that (I) (we) last saw the deceased alive on 10-16-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		
DR. B. SCHINDLER			10/18/68			DR. B. SCHINDLER				43 GREENE ST -CUMBERLAND, MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Oct. 19, 1968		Oldtown Cemetery			Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
James F. Scarpelli, Cumberland, Md.			OCT 22 1968			Charles Judge						

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CUNNINGHAM SACRED HEART HOSPITAL HOLMES FERRY (Wm. B. ...)

MOULDER, J. L. 1963. The ecology of the Great Lakes. University of Michigan Press, Ann Arbor, Michigan. 400 pp.

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2002 HEART HEALTH NATIONAL ACTION PLAN

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13741					13752				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
ALICE			2M.		HUMES	Month Day Year OCT. 11 1968			9:30 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		WHITE		11/18/1893		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Sacred Heart Hospital			none			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Allegany		Lonaconing			11 Front Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Ellsworth C					Crowe	Margaret			Teasdale
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
no					Nelson Humes				Lonaconing, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Colon -</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks or more									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
✓		✓			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		✓		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
		✓		✓					
22a. I certify that (I) (this hospital) attended the deceased from _____, 1968, to 10-11, 1968, that (I) (we) last saw the deceased alive on 10-11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED	
MARTIN M. ROTNSTEIN M.D.								10-12-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
MARTIN M. ROTNSTEIN M.D.		48 BROADWAY - FROSTBURG - MD. 21532							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		10/14/68	St Marys Cemetery			Lonaconing A. Md			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George Eichhorn		Lonaconing, Md.			OCT 14 1968		Charles Judge		

13753

RECORD OF DEATH

13753

13753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13742					13753				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
THOMAS H. HURTT					OCTOBER 29, 1968		5:10 p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		NEGRO		8-11-1903		65 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VIRGINIA		U. S. A.				ALLEGANY Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last week immediately preceding death)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		SELF EMPLOYED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				454 PINE AVE.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
THOMAS HURTT			ELVIRA HURTT NEAL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO			220-16-7195		MEMORIAL HOSPITAL, CUMB.MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH CAUSED BY:								2 weeks	
IMMEDIATE CAUSE (a) <u>450 X</u> <u>Acute Pulmonary Emboli--Pulmonary Infarctions</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
<u>465 X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26</u> , 19 <u>68</u> , to <u>Oct. 29</u> , 19 <u>68</u> , that (I) (<u>X</u>) last saw the deceased alive on <u>Oct. 29, 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) did not view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>[Signature]</u>									10-31-68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR. G. O. HIMMELWRIGHT					CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		11/ 2/1968		Belleville Cemetery		Belleville		?	Virginia
24. FUNERAL DIRECTOR		ADDRESS		Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>[Signature]</u>		John J. Hafer, Jr., 230 Balto Ave. Cumberland				NOV 4 1968		<u>[Signature]</u>	

2452

987654

15214

• 2 •

297-31-025

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13743

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13754

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
John Jay Jackson						10-17-68			10:40						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
Male		White		7/23/47		21 YRS.		MONTHS		DAYS		October 17, 1968			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH			
Keyser W. Va.		U.S.A.										Allegany Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Near Flintstone Md				D.O.A. Memorial Hosp.				Jiffy Car Wash.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Allegany				Cumberland				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET AND NUMBER							
George Jackson				Betty Bell				R.F.D. #1 Cash Valley Rd.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No								Mr. Kenneth Wisenburg R.F.D. #1				Cumberland Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)												SHOCK			
DUE TO, OR AS A CONSEQUENCE OF												1 Hr. 40m			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												INTRAABDOMINAL HEMORRHAGE			
(b)															
DUE TO, OR AS A CONSEQUENCE OF												RUPTURED SPLEEN & LIVER			
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
8254															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				9:00 A.M. 10-17 19 68				Passenger in Auto Accident							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
				Murley's Branch Rd.				R.F.D. 2, Cumberland, Maryland, Allegany							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
Benedict Skitarelic								October 17, 1968							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)							
BENEDICT SKITARELIC, M.D.				CUMBERLAND, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
Burial				10/20/68				Restlawn Memo. Pk.							
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town) (County) (State)				25a. REC'D BY REGISTRAR							
Louis Stein Inc. Cumb. Md.				Cumberland, Allegany Md.				OCT 21 1968							
				25b. REGISTRAR'S SIGNATURE											
				Charles Judge											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MEDICAL CERTIFICATION

MIDDLE										
1. DECEASED-NAME (Type or print)		First CLIFTON		Middle D.		Last JEFFRIES		20. DATE OF DEATH Month Day Year OCTOBER 7, 1968		20. HOUR 4:15 PM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCTOBER 14, 1890		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) FROSTBURG, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done last working life or if retired.) RETIRED MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY JEWELRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 50 BEALL STREET		
14. FATHER'S NAME First Middle Last ALFRED JEFFRIES		15. MOTHER'S MAIDEN NAME First Middle Last MARY J. DAVIS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 214-32-2934		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic Cardio-vascular disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 7-29-68, to 10-7-68, that (I) (we) last saw the deceased alive on 10-6-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE DR. FRED WILLIAMS DR. TOLSON		22c. DATE SIGNED 10-7-68		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT. 9 '68		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532		24a. REC'D BY REGISTRAR DATE OCT 11 1968		24b. REGISTRAR'S SIGNATURE Charles Judge						

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13745

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
FRANK			C.	JEFFRIES	OCT. Month 8 Day 1968 Year		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		DEC. 4, 1884		83 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG		MINERS HOSPITAL		RETIRED PLUMBING		OWN BUSINESS		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		50 BEALL STREET
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
ALFRED				JEFFRIES	MARY		JANE	DAVIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		216-46-0452		DR. WALTER JEFFRIES, FROSTBURG, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>486 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>493 X</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> , 19 <u>68</u> , to <u>10-8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
<u>Martin Rothstein</u>		<u>10-10-68</u>		MARTIN ROTHSTEIN, M. D.				
22e. ADDRESS		22f. ADDRESS						
		48 BROADWAY, FROSTBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		OCT. 11, 1968		F.B.G. MEMORIAL PARK		FROSTBURG, MD.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD. 21532		DATE OCT 14 1968		<u>Charles Judge</u>				

18752

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the original and 2 copies to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13746		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13757	
1. DECEASED-NAME (Type or print) First Middle Last George P. Karoulis			2a. DATE OF DEATH Month Day Year October 5, 1968		2b. HOUR A.M. M. A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3/15/1897		6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Turkey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Allegany County Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired: Miner & Restaurant	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Room 15, Southern Hotel, Cumberland			
14. FATHER'S NAME First Middle Last Pete Karoulis		15. MOTHER'S MAIDEN NAME First Middle Last Peggy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 220-03-757		17. INFORMANT P.O. Box 599, Cumberland, Maryland Allegany County Home records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days you
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 4, 1958 , to Oct. 5, 1968 , that (I) (we) last saw the deceased alive on Oct. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George M. Simons				22c. DATE SIGNED 10/6/68	
22d. PHYSICIAN'S NAME (Type) George M. Simons				22e. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Oct 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md					
24. FUNERAL DIRECTOR H. Lee Silcox - 404 Decatur Street, Cumberland		25a. REC'D BY REGISTRAR OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13747

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13758

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First JOSEPH	Middle L	Lost KASEKAMP	2a. DATE OF DEATH Month 10 Day 14 Year 68			2b. HOUR 8:00 A		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-30-95		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Conductor			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 313 5TH ST.			
14. FATHER'S NAME First JOHN Middle KASEKAMP Lost			15. MOTHER'S MAIDEN NAME First ANNA Middle L Lost STOTT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>1621</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Bronchitis, Emphysema, Pulmonary Fibrosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19____, to <u>1968</u> , 19____, that (I) (we) last saw the deceased alive on <u>10/13/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		DEGREE DR. G. O. HIMMELWRIGHT		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/15/68</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens, Cumberland, Allegany, Md.				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR OCT 18 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

James E. Carpenter, Cumberland, Md.

OCT 12 1958

Burial Oct. 17, 1958 Westlawn Memorial Gardens, Cumberland, All-cary, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13748MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13759

1. DECEASED-NAME (Type or print) First Middle Last Hannah Kear			2a. DATE OF DEATH Month/Day/Year 10/11/68		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 12/25/1892		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md		13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 20 Hill Street
14. FATHER'S NAME First Middle Last William Hawkins		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Crook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Thelma Nicol Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uncontrolled Diabetes 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days years -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2608					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John B. Davis, DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/12/68	
22d. PHYSICIAN'S NAME (Type) John B. Davis		22e. ADDRESS Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg A. Md	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. RECEIVED BY REGISTRAR OCT 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13760

1. DECEASED-NAME (Type or print) First Middle Last Oscar Moble Keckley			2a. DATE OF DEATH at 1:45 P.M. Month Day Year October 24, 1968		2b. HOUR P. M.
3. SEX Male	4. RACE White		5. DATE OF BIRTH 7/17/1889		6. AGE (In years last birthday) 79 YRS.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary Retired: Farmer		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 416 Magruder Street
14. FATHER'S NAME First Middle Last Josiah Keckley			15. MOTHER'S MAIDEN NAME First Middle Last Martha Elizabeth Strosenieder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 234-58-1468		17. INFORMANT P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) gen arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days yes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4500					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 7/14/1966 to 10/24/68 , 19____, that (I) (we) lost saw the deceased alive on 10/23/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George M. Simons				22c. DATE SIGNED 10-24-68	
22d. PHYSICIAN'S NAME (Type) George M. Simons				22e. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-27-68		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
23d. LOCATION (City or Town) (County) (State) Romney, Hampshire, W.Va.		24. FUNERAL DIRECTOR James F. Scatell, Cumberland			
25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE OCT 30 1968					

13760

DEPARTMENT OF HEALTH

10/23/68

at 1:15 p.m. on October 23, 1968

10/23/68

10/23/68

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13750

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13761

1. DECEASED-NAME (Type or Print) Clara E. Kinser			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Oct. 6, 1968			2b. HOUR 2:00 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH April 27, 1903	6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year October 8, 1968 19 2:00 AM		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER RD#3, Bedford Road			14. FATHER'S NAME First Middle Last Bruce Twigg			15. MOTHER'S MAIDEN NAME First Middle Last Martha Hite		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. David Snyder, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ----- PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
				State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 6, 1968		
			ADDRESS (Street, city, town, or county) Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Oliver Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Near Oldtown, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

12721

12721

77



Handwritten text, possibly a signature or date, appearing vertically in the center of the page.

Handwritten text, possibly a signature or date, appearing horizontally in the lower center of the page.

Handwritten text at the bottom left corner, possibly a date or reference number.

Charles Judge

VR A15 (4)
15M 9/60

13752

13752

Henry County

111 Howard Street

111 Howard Street

Clark

Female White

Monrovia

Robert Miles Hoffman

215-28-2925 Miss Agnes Laughlin

Monrovia

None

Robert M. Wilson

Doel, 12, 1928

00114 1988 Richmond, W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13752					13763					
1. DECEASED-NAME (Type or print) (Baby Girl) Lease					2a. DATE OF DEATH Month Day Year 8th Oct. 29 1968			2b. HOUR 3:30 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct 8/29/1968		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Railroad St.	
14. FATHER'S NAME First Middle Last Harry Lease			15. MOTHER'S MAIDEN NAME First Middle Last Shirley Michaels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Harry Lease Lonaconing, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 777x Prematurity DUE TO, OR AS A CONSEQUENCE OF 6 months preg. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs - 6 mos.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 776x										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Oct 8/29/68, to Oct 30/29/68, that (I) (we) last saw the deceased alive on Oct 30/29/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John B. Davis DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 10/30/68					
22d. PHYSICIAN'S NAME (Type) John B. Davis					22e. ADDRESS Frostburg, Md. 21539					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 29 8/30/1968		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.				
24. FUNERAL DIRECTOR ADDRESS George Eichhorn Lonaconing, MD.					25a. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

13131

13131

13131

13131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
13753																		
13764																		
1. DECEASED-NAME (Type or print)			First RUEBEN			Middle OWEN			Last LEWIS			2a. DATE OF DEATH 10 Month 3 Day 68 Year			2b. AMR 11:07A			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 4/5/99			6. AGE (In years last birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY CO., Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CUSTODIAN - BD OF EDUCATION			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN ECKHART			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER						
14. FATHER'S NAME First SAMUEL			Middle THOMAS			Last LEWIS			15. MOTHER'S MAIDEN NAME First ANNIE			Middle BARNARD			Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-01-6651			17. INFORMANT PATIENT'S HOSPITAL CHART									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 412.0 DUE TO, OR AS A CONSEQUENCE OF (b) H A S C V D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 443X																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Dr. Matthew L. Kauffman MD										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10-3-68		
22d. PHYSICIAN'S NAME (Type) DR. MATTHEW L. KAUFFMAN, MD.										22e. ADDRESS SETON DRIVE, CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 10-6-68			23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY			23d. LOCATION (City or Town) (County) (State) ECKHART, MD.									
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE OCT 8 1968			25b. REGISTRAR'S SIGNATURE f Charles Judge									

00761

NOTED 2.1.65
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[illegible]

DR. HILTHELM F. KAFFERNAN, JR.
SECONDRINE, CHLORIDE, 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

13754

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13765

1. DECEASED NAME (Type or print) NORMAN			First	Middle	Last	2a. DATE OF DEATH Month 10 Day 02 Year 68			2b. HOUR A 12:49		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH (11) 1-17-06		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) DISABLED VETERAN 451		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 605 VIRGINIA AVENUE			
14. FATHER'S NAME LEWIS		First		Middle		Last		15. MOTHER'S MAIDEN NAME First (ODELL) MARY FRANCES		Middle LOVELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 284-09-2668		17. INFORMANT 904 SETON DR. SACRED HEART HOSPITAL, CUMB., MD. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 517X IMMEDIATE CAUSE (a) RIGHT HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF PULMONARY FIBROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 6 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 525X CEREBRAL SCLEROSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 63 , to 10-2 , 19 68 , that (I) (we) last saw the deceased alive on 10-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R.W. Ballin, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-2-68	
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22e. ADDRESS 62 GREENE ST., CUMB., MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		23e. REC'D BY REGISTRAR Charles Judge			
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, 108 VIRGINIA AVENUE		25a. DATE OCT 3 1968									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please include carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
13755					13766						
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
MARTHA			ELLEN	LYNCH	Month 10 Day 04 Year 68			5:40 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		WHITE		06-30-90		78 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY COUNTY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		RETIRED CLERK		BEAL'S MARKET					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		MT. SAVAGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		COLUMBIA AVENUE			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOHN			LYNCH	(FLOOD)	MARGARET ALLEN LYNCH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			213-01-8666		SACRD HEART HOSPITAL, 900 SETON DR., CUMB.,			MD. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>4319</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u> <u>NONE</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
✓			✓			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-10-1968</u> , to <u>10-4-1968</u> , that (I) (we) lost the deceased alive on <u>10-4-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
<u>Martin Rothstein</u>									<u>10-4-68</u>		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
MARTIN ROTHSTEIN, M.D.			48 BROADWAY, FROSTBURG, MD. 21532								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/7/1968		St. Patrick's Cath Cem		Mt. Savage		Alleg		Md.	
24. FUNERAL DIRECTOR		ADDRESS		MD. 21502		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HAFFER FUNERAL HOME		230 BALTIMORE AVE., CUMB.				DATE OCT 7 1968		<u>Charles Judge</u>			

13752

13752

04:2 2 01

LYNCH

ELLEN

NORTH

02-20-00

WHITE

FEMALE

ALLEGANY COUNTY

MARYLAND

SACRED HEART HOSPITAL

MARYLAND

COLUMBIA AVENUE

MT. SAVAGE

MARYLAND

MARGARET ALLEN LYNCH

(ELC09)

LYNCH

JOHN

MD. 21502

19-01-666 SACRED HEART HOSPITAL, 000 STON DR., CUMM...

10

W. BROWN, BRISTOL, MD. 21502

10 114 001ST IN, MD.

MD. 21502

HOTEL FEDERAL HILL, 030 BOLLINGER

13756

13767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>			Month	Day	Year	2b. HOUR
FRANK				M.	MARTZ				10	26	68	4:00pm
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
MALE	WHITE	AUG. 23, 1905	63 YRS.	MONTHS	DAYS	HOURS	MIN.	October 26, 1968			4:00pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
MARYLAND		U.S.A.				ALLEGANY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
FROSTBURG			Miners Hospital			TIRE WORKER			KS TIRE PLANT			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
MARYLAND			ALLEGANY			FROSTBURG			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			43 FIRST STREET
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
GEORGE					MARTZ	PHILOMENA					SCALIZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			2320 WALLACE ST., ERIE, PA. 16503			
NO			214-07-0849			MRS. JAMES W. MARTIN,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism,											Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Fracture right femur											12 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
9040												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				1:00 PM 10-26-68				Fell at home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
				Home				43 First Street, Frostburg, Alleg. Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				October 26, 1968				
BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL				OCT. 29 '68		ST. MICHAELS CEMETERY		FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
JOSEPH R. DURST, FROSTBURG, MD. 21532						DATE NOV 4 1968		J Charles Judge				

13767

10766

RECORD OF DEATH

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

MARRIAGE

CHILDREN

PROPERTY

DEBTS

TESTAMENTS

WILLS

INTERESTS

CLAIMS

SETTLEMENTS

ADMINISTRATION

ACCOUNTS

RECEIPTS

PAYMENTS

DISBURSEMENTS

EXPENSES

INCOME

ASSETS

LIABILITIES

EQUITY

VALUATION

ESTIMATION

APPRAISAL

INSURANCE

PROTECTION

SECURITY

SAFETY

GUARANTEE

WARRANTY

ASSURANCE

CONFIDENCE

TRUST

FAITH

HOPE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13757

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13768

1. DECEASED-NAME (Type or Print)			First <i>Regina</i>			Middle <i>Mae</i>			Last <i>Merkel</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct.</i> Day <i>7,</i> Year <i>1968</i>			2b. HOUR <i>11:15</i>								
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 14, 1917</i>		6. AGE (In years last birthday) <i>51</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <i>Oct.</i> Day <i>7,</i> Year <i>1968</i>			2d. HOUR <i>11:15</i>								
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Allegany</i>											
10. CITY OR TOWN OF DEATH <i>Cumberland,</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA Memorial Hosp.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife & Clerk,</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Stores</i>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Allegany</i>				13c. CITY OR TOWN <i>Cumberland,</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>511 Fayette St.</i>											
14. FATHER'S NAME First <i>John</i>				Middle <i>--</i>				Last <i>Fulton</i>				15. MOTHER'S MAIDEN NAME First <i>Margaret</i>				Middle <i>--.</i>				Last <i>O'Baker</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>214-07-2334</i>				17. INFORMANT ADDRESS <i>Mr. Victor N. Merkel 511 Fayette St. Camb. Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100</i> <i>CORONARY OCCLUSION</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>CORONARY SCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>--</i>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i> <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						Oct. 7, 1968 22b. DATE SIGNED <i>Rt. # 9</i>											
EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M. D.</i>						ADDRESS (Street, city, town, or county) <i>Cumberland, Md.</i>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>10/10/68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>SS. Peter & Paul Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany, Md.</i>											
24. FUNERAL DIRECTOR <i>H. Wayne George Cumberland, Maryland</i>										25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>													

85751

553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13758

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13769

1. DECEASED-NAME (Type or print) ^{First} HENRY ^{Middle} Frederick ^{Last} MEYERS			2a. DATE OF DEATH Month 10 Day 12 Year 68		2b. HOUR 2:20 PM			
3. SEX MALE	4. RACE WHITE		5. DATE OF BIRTH 4-23-1897		6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PITTS. PA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Ret. engineer		12b. KIND OF BUSINESS OR INDUSTRY Brewery		
13a. USUAL RESIDENCE (Where deceased admission) STATE W. VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 159 MAIN ST.,
14. FATHER'S NAME ^{First} HENRY ^{Middle} S. ^{Last} MEYERS			15. MOTHER'S MAIDEN NAME ^{First} ANNA ^{Middle} ^{Last} HECK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not, or unknown		16b. SOCIAL SECURITY NO. 214-05-4825		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with incomplete L. hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Obstructive Emphysema with advanced pulmonary insufficiency</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>?</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>577 Diabetes mellitus mild 10 years</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Dec.</u> , 19 <u>68</u> , to <u>12 Oct.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11 Oct.</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>W. A. Van Ormer, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>13 Oct 68</u>				
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/15/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

13752

REPORT OF DEATH

13752

NAME: HENRY, FREDERICK
AGE: 10
SEX: MALE
RACE: WHITE
DATE OF BIRTH: 4-23-1901

PLACE OF BIRTH: ALBANY, NEW YORK

RESIDENT: 1112 W. 8th St., ALBANY, N.Y.

DECEASED: 11-1-1911

CAUSE OF DEATH: TUBERCULOSIS OF LUNGS

DATE OF DEATH: 11-1-1911

PLACE OF DEATH: ALBANY, N.Y.

DATE OF BURIAL: 11-1-1911

PLACE OF BURIAL: ALBANY, N.Y.

NAME OF FUNERAL HOME: ALBANY, N.Y.

NAME OF MINISTER: ALBANY, N.Y.

NAME OF CHURCH: ALBANY, N.Y.

NAME OF CEMETERY: ALBANY, N.Y.

NAME OF INTERVIEWER: ALBANY, N.Y.

NAME OF WITNESS: ALBANY, N.Y.

NAME OF SIGNER: ALBANY, N.Y.

NAME OF OFFICIAL: ALBANY, N.Y.

NAME OF CITY: ALBANY, N.Y.

NAME OF STATE: ALBANY, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13759

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13770

1. DECEASED-NAME (Type or print)		First COLUMBUS	Middle J	Last MILLER	20. DATE OF DEATH OCT. Month 14 Day 1968		2b. HOUR 3:30a				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 20, 1873		6. AGE (In years last birthday) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH WESTERNPORT, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RURAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY PAPER MILL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARY LAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RURAL			
14. FATHER'S NAME First SAMUEL		Middle MILLER		Last MILLER		15. MOTHER'S MAIDEN NAME First MARY		Middle WILT		Last WILT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219 56 9562		17. INFORMANT Address Mrs. Leonard Glise Cleveland, Ohio					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 week 10 yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May, 1962, to Oct 14, 1968, that (I) (we) lost saw the deceased alive on 10-12-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William W. Loh		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY		23d. LOCATION (City or Town) WESTERNPORT		(County) ALLEGANY		(State) Md.	
24. FUNERAL DIRECTOR E. L. Bual		25a. REC'D BY REGISTRAR DATE OCT 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

13338

1990

• 1997-1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13760										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13771																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
James D. Miller										10/30/68										10:30 P.M.																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
M										W.										Oct. 24 1877										91 YRS.										6																			
7a. BIRTHPLACE (State or foreign)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Shantsville, Md.										U.S.																				Allegheny										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Cumberland										Cumberland Nursing Home										Contractor																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Allegheny										Cumberland										5 S. H. V. Industrial																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
James D. Miller										Ellen Keynolds																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										213-18-2188										Mrs. J. E. Blanton										Blanton																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
2509										IMMEDIATE CAUSE (a) <u>Renal failure</u>										1 1/2 months																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u>										years																																							
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
Generalized arteriosclerosis																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>68</u> , to <u>10/30</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>10/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Andrew Stasko MD										10/31/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Dr. Andrew Stasko, MD										401 Decatur St., Cumberland, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										Nov. 2, 1968										Hillcrest Burial Park										Cumberland, Allegheny, Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
James F. Scarpelli, Cumberland, Md.																				NOV 6 1968										Charles Judge																													

18771

DEPARTMENT OF DEATH

18771

18771

18771



James E. Campbell, Cumberland, Md.
Nov. 2, 1968
Burial: Wilcox Funeral Home, Cumberland, Md.
Nov. 6, 1968
Dr. Andrew Steaks, MD
401 Decatur St., Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13772

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
WALTER GRANT MORRIS, JR.						October 17, 1968			4 p M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male		White		March 11, 1920			48 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland		U.S.A.					Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Clerk			Post Office		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany			Cumberland		YES		403 Fayette Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Walter Grant Morris			Emma Belle Smouse								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			WW II & Korea			215-14-6261			Esther Violet Morris, 403 Fayette St., Cumb. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Widespread Metastatic Carcinoma Rectum</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rectal Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 mos.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>154X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/8/68</u> , to <u>10/17/68</u> , that (I) (we) last saw the deceased alive on <u>10/17/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. Himmler</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/19/68			
22d. PHYSICIAN'S NAME (Type) Walter N. Himmler, M.D.						22e. ADDRESS 412 N. Mechanic St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		10-21-68		Sunset Memorial Park				Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR John J. Hafer, Jr., 230 Balto. Ave., Cumberland, Md.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
						OCT 22 1968					

13773

13773

DATE: 10/10/68 TO: DIRECTOR, FBI FROM: SAC, NEW YORK (100-100000)

SUBJECT: ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR SUBJECT OF NEW YORK

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 9, 1968.

ON OCTOBER 8, 1968, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM AN INDIVIDUAL WHO OFFERED TO ASSIST IN OBTAINING A PASSPORT FOR SUBJECT OF NEW YORK.

THE INDIVIDUAL STATED THAT HE HAD BEEN CONTACTED BY AN INDIVIDUAL WHO OFFERED HIM \$5,000 TO ASSIST IN OBTAINING A PASSPORT FOR SUBJECT OF NEW YORK.

THE INDIVIDUAL STATED THAT HE HAD REFUSED THE OFFER AND WANTED TO REPORT THE MATTER TO THE FBI.

THE NEW YORK OFFICE IS CURRENTLY CONDUCTING AN INVESTIGATION OF THE MATTER AND WILL REPORT THE RESULTS OF THE INVESTIGATION TO THE BUREAU.

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13762

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SIDNA A. MOYER			2a. DATE OF DEATH 10 Month 5 Day 68 Year			2b. HOUR P 6:30 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/2/97		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during HOUSEWIFE - CHINESE)		12b. KIND OF BUSINESS OR INDUSTRY CHINESE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN ELLERSLIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER NONE	
14. FATHER'S NAME First Middle Last WILLIAM MORRISON			15. MOTHER'S MAIDEN NAME First Middle Last MARGARETT KYLE MOYER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (NO OWN) (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO. 214 07 2609			17. INFORMANT HOSPITAL RECORDS			18. ADDRESS 900 SETON DRIVE CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of rectum, brain, 150X DUE TO, OR AS A CONSEQUENCE OF Cervical Nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/20/68 8/20/68									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 150X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1948 , to 10/5/68 , that (I) (we) lost the deceased alive on 10/5/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. S.G. Weisman				22c. DATE SIGNED 10/5/68		22d. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN			
22e. ADDRESS 59 GREENE STREET									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Maryland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13763		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13774	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last DAVID CLAIR MULLEN			2a. DATE OF DEATH Month Day Year OCTOBER 3 1968			2b. HPM 4:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 29 1883		6. AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) RAMEY, PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) KINCH REST HOME		12a. USUAL OCCUPATION (Kind of work done during last year or during previous year) RETIRED GLASS WORKER		12b. KIND OF BUSINESS OR GLASS CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PA.		13b. COUNTY FAYETTE		13c. CITY OR TOWN CONNELLVILLE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last JOHN MULLEN		15. MOTHER'S MAIDEN NAME First Middle Last PRISCILLA WISE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 178-07-3641		17. INFORMANT GEORGE INGRAM 204 W. GREEN ST. CONNELLVILLE PA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> 492x DUE TO, OR AS A CONSEQUENCE OF <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis & Scurfation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocarditis & Scurfation</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 5277						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs. 3 yrs. 6 mos.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1968</u> to <u>Oct 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Clay E. Durrett</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/3/68			
22d. PHYSICIAN'S NAME (Type) CLAY E. DURRETT				22e. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT 6, 1968		23c. NAME OF CEMETERY OR CREMATORY GREENRIDGE MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CONNELLVILLE FAYETTE PA.	
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST. CUMBERLAND, MD				25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

157751

06131

TO: DIRECTOR, FBI (100-371101) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68, RE: JAMES EARL RAY, AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13775

1. DECEASED-NAME (Type or Print)		First Jacob		Middle Oscar		Last Mullenax		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Oct. 10, 1968		2b. HOUR 2:00 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Apr. 4, 1903	6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Oct. 10, 1968		2d. HOUR 2:00 AM	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Blacksmith Hlpr.				12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 506 Pine Ave.			
14. FATHER'S NAME First Middle Last Benjamin -- Mullenax		15. MOTHER'S MAIDEN NAME First Middle Last Sara -- VanMeter									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-14-5615		17. INFORMANT ADDRESS Mrs. Lenora Mullenax, 506 Pine Ave., Cumb. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 2 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Oct. 10, 1968		22b. DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # 9					
				ADDRESS (Street, city, town, or county) Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card of paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13765					13776					
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH at 1:30 P.M.					2b. HOUR
Margaret Ann Myers					October 24, 1968					P. M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		Nov. 24, 1882		85 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
W. Virginia		U. S. A.				Allegany County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Allegany County Infirmary			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Allegany		Nikep		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Peter Bowman					Matilda Doman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
			220-03-7971D		P.O. Box 599, Allegany County Infirmary records.			Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u>										5 days
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Generalized Arteriosclerosis</u>										yes
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
331X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year							
			P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1961, to Oct. 24, 1968, that (I) (we) lost saw the deceased alive on Oct. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
George M. Simons									22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
George M. Simons						Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10/27/68		Laurel Hill Cemetery			Moscow A. Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR	
George Eichhorn						Lonaconing, Md.			DATE	
						OCT 28 1968			25b. REGISTRAR'S SIGNATURE	
									Charles Judge	

8556

2576

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13766

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13777

1. DECEASED-NAME (Type or print) Anna L. Neat			2a. DATE OF DEATH Oct. Month 29 Day 1968			2b. HOUR 5:30 ^A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 26, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 504 Ridgewood Ave.	
14. FATHER'S NAME First Middle Last George Louis Layman				15. MOTHER'S MAIDEN NAME First Middle Last Anna Louise Crowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Sylvia Spurrier, Baltimore, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1702 Epidural cancer of the spine DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 to 6 wks? -		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1962 Arterioclerotic coronary artery heart disease										
19a. DATE OF OPERATION ✓		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ✓						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓		21f. LOCATION Street or R.F.D. No. City or Town County State ✓						
22a. I certify that (I) (this hospital) attended the deceased from July 1964 , to 10-29, 1964 , that (I) (we) last saw the deceased alive on 10-29, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Martin M. Rotstein				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-31-68				
22d. PHYSICIAN'S NAME (Type) MARTIN M. ROTSTEIN M.D.				22e. ADDRESS 48 BROADWAY - FROSTBURG, MD. 2152						
23a. BURIAL, CREMATION, REBURY (Specify) Reburial		23b. DATE Oct. 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Md. Allegany				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

13768

13777

Ann I. Hart Oct. 29 1968 2:30

Male White April 26, 1961 77

Married USA X Allegany

Prostatectomy Mine's Hospital Housewife

Mo. Allegany Cumberland X 704 Richmond Ave.

George Louis Payne Anna Louise Crowe

no Mrs. Sylvia Spentler, Baltimore, Md.

Dec. 31, 1968 - Baltimore, Maryland

James A. Campbell, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13778

1. DECEASED-NAME (Type or print) CHARLES			First Middle Last CHARLES NMI NEVY			2a. DATE OF DEATH Month 10 Day 09 Year 68			2b. HOUR 2:15P		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 08-18-13-84			6. AGE (In years at birth) 34 YRS.		
7a. BIRTHPLACE (State or foreign country) ITALY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) RETIRED OFFICER			12b. KIND OF BUSINESS OR OCCUPATION Macaroni Mfg.		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 510 PRINCE ST.			14. FATHER'S NAME First Middle Last ANTHONY NEVY			15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO. 216-18-1616			17. INFORMANT SACRED HEART RECORD SETON DR., CUMB., MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis contracted kidneys DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 1 year 4 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-18-1961 to 10-9-1968 , that (I) (we) last saw the deceased alive on 10-9-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. L. Brings						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10-10-68		
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS						22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, OTHER (Specify)			23b. DATE Oct. 12, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR SCARPELLI James F. Scarpelli, Cumberland Md.						25a. REC'D BY REGISTRAR DATE OCT 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13768		CERTIFICATE OF DEATH						13779	
1. DECEASED NAME (Type or print)		First HESTER		Middle NMI		Last PAUL		2a. DATE OF DEATH Month <u>10</u> Day <u>05</u> Year <u>68</u>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 08-01-94		6. AGE (In years lost birthday)		7b. HOUR 8:45A	
7a. BIRTHPLACE (State or foreign) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		IF UNDER 1 YEAR MONTHS DAYS	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE		IF UNDER 24 HRS. HOURS MIN.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 352 BEDFORD ST.	
14. FATHER'S NAME First GEORGE		Middle W.		Last DAVIDSON		15. MOTHER'S MAIDEN NAME First ETHEL		Middle LYNNE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>NO</u> (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-07-4089		17. INFORMANT Address HOSPITAL RECORD SETON DR., CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>403X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic contracted kidneys</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u> <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>446X diabetes</u>									
19a. DATE OF OPERATION <u>9-23-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>arterial bypass</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-4</u> , 19 <u>68</u> , to <u>10-5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>E. Brings MD</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-5-68</u>			
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS		22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/68		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR ADDRESS SILCOX-MERRITT 404 DECATUR ST., CITY		25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

404 DECATUR ST. ST. CITY

DR. L. J. BRIDGES

27 GREEN ST., CUMFERTLAND, MD. 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13769					13780				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last JOSEPH FRANCIS PAUL					Month Day Year OCT. 20th, 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		2b. HOUR	
MALE		WHITE		JULY 20th, 1904		64 YRS.		12 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
MT. SAVAGE,		R.R. STREET		NONE		NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		MT. SAVAGE,				R. R. STREET	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last JOHN PAUL		First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO		215-12-7229		Mrs. Idella R. Paul, Mt. Savage, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary occlusion arteriosclerotic heart disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to Oct 20 1968, that (I) (we) last saw the deceased alive on Oct 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Davis MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/22/68			
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.				22e. ADDRESS 2 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10-23-68		ALLEGANY COUNTY CEMETERY		CUMBERLAND, ALLEGANY, MD.			
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE OCT 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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RECEIVED BY DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First MARY		Middle E.		Last PORTER		2a. DATE OF DEATH Month OCTOBER Day 18 Year 1968		2b. HOUR 11:00 PM		
3. SEX FEMALE		4. RACE WHITE			5. DATE OF BIRTH MARCH 25, 1879			6. AGE (In years lost birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.						
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 189 ORMOND STREET			
14. FATHER'S NAME First WILLIAM Middle MATTHEWS Last ISABEL			15. MOTHER'S MAIDEN NAME First ISABEL Middle BERNARD Last BERNARD										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 218-48-9547			17. INFORMANT Address MRS. HAZEL KEEDY, FROSTBURG, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrhythmia 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Coronary sclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of rectum, untreated; Carcinoma of breast.													
19a. DATE OF OPERATION 10/16/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of breast.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 14, 1968 , to Oct 18, 1968 , that (I) (we) last saw the deceased alive on Oct 18 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (the) (did) (not) view the body after death.													
22b. SIGNATURE Alvin J. Walters MD. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/20/68					
22d. PHYSICIAN'S NAME (Type) Alvin J. Walters, M. D.						22e. ADDRESS 48 Broadway, Frostburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, MD.							
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE O'Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13771

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13782

1. DECEASED-NAME (Type or print) NINA		First T.		Middle QUINN		Last		2a. DATE OF DEATH Month OCTOBER Day 7 , Year 1968		2b. HOUR A MIN. 1:50	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 29, 1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.		13b. COUNTY HAMPSHIRE		13c. CITY OR TOWN ROMNEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 176 GRAFTON STREET			
14. FATHER'S NAME First EDWARD Middle TAYLOR Last 		15. MOTHER'S MAIDEN NAME First ANNIE Middle WILSON Last 									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 232-26-5032		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address 							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) H. A. S. Corbush disease with Cardiomegaly DUE TO, OR AS A CONSEQUENCE OF (c) Chronic atrial fibrillation etc last. 2509 260x APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 5 years 9 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypothyroidism 12 years, Post Cholecyst											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 17 July, 1968 , to 7 Oct. , 1968, that (I) (we) last saw the deceased alive on 6 Oct , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.A. Van Ormer, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7 Oct. 68					
22d. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		22e. ADDRESS 122 SO. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-9-68		23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		23d. LOCATION (City or Town) (County) (State) Romney, W. Va. Hamp. Co.					
24. FUNERAL DIRECTOR James F. Scuffell, Cumberland, Md.		ADDRESS		25a. DEATH BY REGISTRATION DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE James F. Scuffell					

13783

CERTIFICATE OF DEATH

13783

NAME: [illegible] SEX: [illegible] DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

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NAME OF CLERGYMAN: [illegible]

NAME OF CLERGYMAN: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13772

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13783

1. DECEASED-NAME (Type or print)		First John	Middle Henry	Last Race	2a. DATE OF DEATH Month Day Year October 12, 1968		2b. HOUR A. M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH NOVEMBER 18, 1879		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal Mining			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route No. 1	
14. FATHER'S NAME First Middle Last Justus Race		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Deal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. N.A.		17. INFORMANT P.O. Box 599, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Bronchial Asthma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Her you you							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 29, 1968, to Oct. 12, 1968, that (I) (we) last saw the deceased alive on Oct. 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George M. Simons, M.D.		22c. DATE SIGNED Oct. 12, 1968		22d. PHYSICIAN'S NAME (Type) George M. Simons, M.D.					
22e. ADDRESS Memorial Hospital, Cumberland, Md.		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/14/68		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, ALLEGANY, MD.			
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

18788

DEPARTMENT OF HEALTH

18788

NAME: [illegible] SEX: [illegible] RACE: [illegible] BIRTH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible]

EDUCATION: [illegible] RELIGION: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]

DATE OF CREMATION: [illegible] PLACE OF CREMATION: [illegible]

DATE OF EXHUMATION: [illegible] PLACE OF EXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

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DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. File 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13773

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13784

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Frank B. Ratke						Month Day Year Oct. 5, 1968			10:30 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Oct. 21, 1893	74 YRS.	MONTHS	DAYS	HOURS	MIN	October 5, 1968			10:30 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital-DOA			Retired Yard Foreman			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Allegany			Cumberland		YES		420 South St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last Stephen Ratke			First Middle Last Augusta Rollocker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
no						Mrs. Marie Ratke, Cumberland, Md. Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> Coronary Occlusion										Sudden	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Coronary Sclerosis	
DUE TO, OR AS A CONSEQUENCE OF										-----	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>4201</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 5, 1968			
						ADDRESS (Street, city, town, or county)		Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Oct. 8, 1968		St. Mary's Cemetery		Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						DATE OCT 9 1968		J Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1 (11)
30M REV. 1/68

13774												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												13785											
1. DECEASED-NAME (Type or print) MARGARET A. RICHARDS												2a. DATE OF DEATH Month OCTOBER Day 2 Year 1968												2b. TIME OF DEATH 12:55											
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH 4-3-1890				6. AGE (In years last birthday) 78 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS. HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY								Md.															
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of last year) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN FROSTBURG				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 191 SOUTH WATER ST.																			
14. FATHER'S NAME First HENRY Middle WELLINGS Last SARAH				15. MOTHER'S MAIDEN NAME First SARAH Middle LEWIS Last LEWIS																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic Carcinoma of Stomach 2 years 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 151X																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnosis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2 Oct , 19 68 , that (I) (we) last saw the deceased alive on 1 Oct , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Dr. Frederick Miltenberger												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10-9-68																			
22d. PHYSICIAN'S NAME (Print) DR. FREDERICK MILTENBERGER												22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Oct 4				23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park				23d. LOCATION (City or Town) (County) (State) Frostburg Alleg. Md.																							
24. FUNERAL DIRECTOR Joseph R. Dorst												ADDRESS Frostburg Md.				25a. REC'D BY REGISTRAR OCT 11 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge															

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WILSON, RICHARD S. OCTOBER 2, 1958 11:30

WHITE 4-3-1920

U.S.A. 100-100000

GENERAL HOSPITAL 100-100000

100-100000 100-100000

LEWIS 100-100000

GENERAL HOSPITAL, CUMBERLAND, MD.

DR. FREDERICK MILLER 100-100000

OCT 11 1958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13775

13786 AM 12:30

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) ROBERT			First LEE			Middle ROBERTS			Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year October 8, 1968			2b. HOUR 12:30a		
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 5, 1923		6. AGE (in years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Oct. 8, 1968			2d. HOUR 12:30a		
7a. BIRTHPLACE (State or foreign country) W, Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany				Md.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial Hospital-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W, Va.				13b. COUNTY Hampshire				13c. CITY OR TOWN Green Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rural					
14. FATHER'S NAME John				First Roberts				Middle Rachesl				Last Dawson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO. World War II 233-30-5297				17. INFORMANT Lillian E. Roberts,				ADDRESS Green Spring, W, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN " ----			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarellic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED October 8, 1968					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Oct. 10, 1968				23c. NAME OF CEMETERY OR CREMATORY Forest Glen				23d. LOCATION (City or Town) (County) (State) Green Spring, Hamp. W, Va.					
24. FUNERAL DIRECTOR [Signature]				ADDRESS Romney, W, Va.				25a. REC'D BY REGISTRAR DATE OCT 10 1968				25b. REGISTRAR'S SIGNATURE [Signature]					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any data not necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13776		13787	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First		Middle		Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Dorothy M. Schreiber										Month Day Year		6:15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female		White		June 9, 1912		56 YRS		MONTHS DAYS		HOURS MIN		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Wisc.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			D.O.A. Memorial Hospital			Housewife			Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
W. Va.			Mineral			Wiley Ford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			None	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Frank Trask			Ida Sharkey										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no						Mr. Charles Schreiber, Sr.			Wiley Ford, W. Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										Coronary Occlusion		Sudden	
IMMEDIATE CAUSE (a)													
4109 DUE TO, OR AS A CONSEQUENCE OF										Coronary Sclerosis		--	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)			
										(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Oct. 29, 1968				
EXAMINER'S NAME (Type)			Dr. Benedict Skitarelic, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			Rt. 9 Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		Nov. 2, 1968		Sunset Memorial Park		Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.						NOV 4 1968		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13777					13788					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR A.M.		
First Middle Last Eddie Juanita Schumacher					Oct. Month 3, Day 68 Year			3:30 M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Sept. 1, 1898		70 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U. S. A.				Allegany Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland,			605 Lincoln St.			Housewife,		Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland,		YES		605 Lincoln St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Burd Sterner			Mary Snyder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.			None		Mr. Peter Schumacher, 605 Lincoln St. Cumb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordless Herpesvirus pneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF <u>7 months</u> (b) <u>hemolytic anemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>year</u> (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>65</u> , to <u>Oct 3</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Sept 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. Schindler</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>Oct 3, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>Blane M. Schindler, M. D.</u>					22e. ADDRESS <u>43 Greene St. Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/5/68		Sunset Memorial Park		Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Maryland</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
					OCT 7 1968		<u>Charles Judge</u>			

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References

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3. *Journal of the American Medical Association*, 1964; 191: 100-101.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13789

| | | | | | | | | | | | |
|---|--|------------------------------|--|--|-------------------|--|---|-----------------|--|------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR A | | |
| KARLA | | | Dee | | SHINGLETON | OCTOBER 4, 1968 | | | 4:45 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | WHITE | | SEPTEMBER 19, 1968 | | YRS. MONTHS DAYS | | 14 | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| KEYSER, W. VA. | | U.S.A. | | | | ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND, MD. | | | MEMORIAL HOSPITAL | | | None | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Keyser, W. VA. | | | MINERAL | | KEYSER | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 79 2ND STREET | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| RICHARD SHINGLETON | | | VICKY WILT | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | No | | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Purulent spinal meningitis</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Herobacter Aerogenes</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 3403 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | City or Town County State | | |
| | | | | | | Street or R.F.D. No. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-2-</u> , 19 <u>68</u> , to <u>10-4-68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10-4-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| <u>DR. ROBERT BRODELL</u> | | | | | | | | | 10-4-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| DR. ROBERT DAWSON | | | 500 GREENE ST., CUMBERLAND, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 10-6-68 | | | Queens Point Cemetery | | | Keyser, W. Va. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| <u>Harold W. McKenzie</u> | | | Keyser, W. Va. | | | OCT 7 1968 | | | <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 13779 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 13790 | | | |
| 1. DECEASED-NAME (Type or print) First MINNIE Middle E Last SHUMAKER | | | | | | | | | | | | 2a. DATE OF DEATH Month OCTOBER Day 1 Year 1968 | | | | | | | | | | | | 2b. HOW AM 3:00 M | | | |
| 3. SEX FEMALE | | | | 4. RACE WHITE | | | | 5. DATE OF BIRTH 5-24-1884 | | | | 6. AGE (In years last birth (Y) 84 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) BEDFORD, PA. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. COUNTY OF DEATH ALLEGANY Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH CUMBERLAND | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HWY. | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | | 13b. COUNTY ALLEGANY | | | | 13c. CITY OR TOWN CUMBERLAND | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER ROUTE 6, BOX 197 | | | | | | | | | | | |
| 14. FATHER'S NAME First HOWARD Middle DEFF Middle LAST BAUGH | | | | 15. MOTHER'S MAIDEN NAME First MARY Middle UMBACH Last | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4379 DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days 10 hrs | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334x | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING, <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6/67, 19 to 10/1/68, that (I) (we) last saw the deceased alive on 10/1/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 10/2/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS | | | | 22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 10/3/1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Charles E. Hafer | | | | ADDRESS Charles E. Hafer, 230 E. Baltimore Ave. Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR OCT 4 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | |

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OCTOBER 7 1968 8:00

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MEMORIAL HOSPITAL, CUMBERLAND

123 S. CENTRE ST., CUMBERLAND

DR. P. J. WILLIAMS

OCT 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13780

CERTIFICATE OF DEATH

13791

| | | | | | | | | | | | |
|---|--|--|--|--------|------|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) MARTHA | | | First | Middle | Lost | 2a. DATE OF DEATH
OCT. Month 7 Day 1968 Year | | | 2b. HOUR
M | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
FEB. 23, 1885 | | | 6. AGE (In years last birthday)
83 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH
FROSTBURG | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MINERS HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WORK | | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
ALLEGANY | | | 13c. CITY OR TOWN
MIDLOTHIAN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
EDGAR | | | First | | | Middle | | | Last | | |
| 15. MOTHER'S MAIDEN NAME
AMELIA | | | First | | | Middle | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
219-54-2095 | | | 17. INFORMANT
MRS. WM. CUTTER, MIDLOTHIAN, MD. | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE BRAIN SYNDROME
401X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CIRCULATORY DISTURBANCE
DUE TO, OR AS A CONSEQUENCE OF
(c) HYPERTENSIVE VASCULAR DISEASE
10 YEARS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
34 WEEKS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
447X Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 18, 1968 , to Oct. 7, 1968 , that (I) (we) last saw the deceased alive on Oct. 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. Paige Strong | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
10/7/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
A. PAIGE STRONG, M. D. | | | | | | 22e. ADDRESS
E. MAIN ST., FROSTBURG, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
OCT. 10 '68 | | | 23c. NAME OF CEMETERY OR CREMATORY
FBG. MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | | |
| 24. FUNERAL DIRECTOR
J. R. DURST, FROSTBURG, MD. | | | | | | ADDRESS
21532 | | | 25a. REC'D BY REGISTRAR
DATE OCT 14 1968 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

10701

10701

10701

Acute Brain Syndrome

Circulatory Disturbance

Hypertensive Vascular Disease

Diabetes Mellitus

x

Oct 1

Oct 18 1968

Diagnosis

Diagnosis

OCT 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 13781 | | | | | | | | | | | |
| 13792 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Emory Lee Smith | | | | | 2a. DATE OF DEATH at 4:00 P.M.
October 5, 1968 | | | | | 2b. HOUR
P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2/18/1881 | | | 6. AGE (In years last birthday)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany County | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Allegany County Infirmary | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired: B & O Machinist | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
26 Hawthorne Street | | |
| 14. FATHER'S NAME First Middle Last
Harry James Smith | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Jane Neikirk | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT P.O. Box 599, Cumberland, Md.
Allegany County Infirmary records. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
1550 IMMEDIATE CAUSE (a) Carcinoma of metastases
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Atherosclerosis
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1550 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1967 , to Oct. 5, 1968 , that (I) (we) lost saw the deceased alive on Oct. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George M. Simmons | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
George M. Simmons | | | | | 22e. ADDRESS
Memorial Hospital, Cumberland, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Oct. 8, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md | | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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Dr. J. G. Thompson

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Memorial Hospital, London, and the

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 13782 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 13793 | |
|---|---------|------------------------------|--|--|------|---|------|--|-----------------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| LAFAYETTE P. SMITH | | | | | | OCT. 25 1968 | | | 11 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| MALE | WHITE | APRIL 20, 1889 | 79 YRS. | MONTHS | DAYS | HOURS | MIN. | OCT. 25 1968 | 11 PM | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MARYLAND | | USA | | | | ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND | | | DOA MEMORIAL HOSPITAL | | | RET. FARMER | | | FARM | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | ALLEGANY CUMBERLAND | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | WILLIAMS ROAD, ROUTE 2, | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| MARTIN V. SMITH | | | MARY CESSNA | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| YES | | | WW 1 218 30 0765 | | | BETTY N. SMITH, ROUTE 2, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | SUDDEN | |
| IMMEDIATE CAUSE (a) 4109 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| CORONARY OCCLUSION | | | | | | | | | | | |
| CORONARY SCLEROSIS | | | | | | | | | | ---- | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| Benedict Skitarelic | | | M.D. | | | OCT. 25, 1968 | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (City, town, or county) | | | | | |
| BENEDICT SKITARELIC, M.D. | | | XX | | | ROUTE 2, CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | OCT. 28, 1968 | | FAIRVIEW CEMETERY | | ARTEMAS, PA. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| BYRON KIGHT | | | CUMBERLAND, MD. | | | OCT 29 1968 Charles Judge | | | | | |

13103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A13
30M REV. 5-58

| 13783 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 13794 | |
|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
TERESA B. SMITH | | | | 2a. DATE OF DEATH Month Day Year
OCTOBER 8, 1968 | | 2b. HOUR MIN.
12:25 A | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3-18-94 | | 6. AGE (In years last birthday) YRS.
74 | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
RT.#5 BOX 377 CUMB., MD. | | 13f. CITY OR TOWN
CUMBERLAND | | 13g. STATE
MD. | | 13h. ZIP CODE
21502 | |
| 14. FATHER'S NAME First Middle Last
WILLIAM WRIGHT | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
SUSAN R. BEEMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
NO | | 16b. SOCIAL SECURITY NO.
217-10-5011 | | 17. INFORMANT
SACRED HEART HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 DIABETES MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-6, 1968 , to 10-8, 1968 , that (I) (we) last saw the deceased alive on 10-7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
L. Michael Glick | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-9-68 | |
| 22d. PHYSICIAN'S NAME (Type)
BRADDOCK MEDICAL GROUP L. MICHAEL GLICK, M.D. | | 22e. ADDRESS
912 SETON DRIVE, CUMB., MD. 21502 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/10/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Porter Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Eckhart Alleg Md. | |
| 24. FUNERAL DIRECTOR
Charles E. Hafer | | ADDRESS
230 Balto Ave. Cumberland, Md | | 25a. REC'D BY REGISTRAR
OCT 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

2251

025097



DISCUSSION

CHIEF, JR.

CHAIYONG

WILLIAM

F. MICHAEL GLICK, M.D.
300 ROCK MEDICAL GROUP

913 2104 011E, COMB., MD. 81708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|-----------------------------------|--|--------------------|
| 13784 | | | | | 13795 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| First | | | Middle | | Last | | | Month | Day | Year | Hour |
| DESSIE | | | E. | | SPIKER | | | OCTOBER | 30 | 68 | 8:30A ^M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | | WHITE | | 4/21/98 | | | 70 | | MONTHS | DAYS | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| PENNSYLVANIA | | UNITED STATES | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | ALLEGANY CO., Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND, MD. | | | SACRED HEART HOSPITAL | | | HOUSEWIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| PENNSYLVANIA | | | SALISBURY | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RT. #1, BOX 128 | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| JOHN | | | PEARCE | | MARY | | ELIZABETH | | SPIKER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| NO | | | 220 32 4414 | | PATIENT'S HOSPITAL CHART | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | | 2 DAYS | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 - 29, 1968, to 10 - 30, 1968, that (I) (we) lost saw the deceased alive on 10 - 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| Rept. W. Ballin M.D. | | | | | | 10-31-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| DR. R. W. BALLIN | | | | | | 62 GREENE STREET, CUMBERLAND, MD. 21502 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 11/2/68 | | Grantsville Cemetery | | Grantsville, Garrett, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Rich Newman | | | | Grantsville, Md. | | NOV 8 1968 | | Charles Judge | | | |

13795

DEPARTMENT OF HEALTH

13795

DEPT. OF HEALTH
 DIVISION OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 100 NORTH ZEEB ROAD
 ANN ARBOR, MICH. 48106
 TELEPHONE 763-1111
 FAX 763-1112
 HOURS: 8:00 A.M. - 5:00 P.M.
 MONDAY - FRIDAY
 10-15-82

DIAGNOSTIC REPORT

DR. R. M. MILLER
 10 - 20 - 82
 10 - 20 - 82
 10 - 20 - 82
 10 - 20 - 82

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13785

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13796

| | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|-------------------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR | | |
| MILDRED | | | LEONA | | | SPIKER | | | 2:00a M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR | | |
| FEMALE | WHITE | 9/13/23 | 45 YRS. | | | October 5, 1968 | | | 8:00a M | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| LONACONING, MD. | | | U.S.A. | | | | | | ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FROSTBURG | | | Miner's Hospital--DOA | | | HOUSEWIFE | | | OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| MARYLAND | | | ALLEGANY | | | FROSTBURG | | | 201 BOWERY STREET | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| JAMES GREEN | | | LUCINDA BROADWATER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | N.A. | | | 215-16-4476 | | | MR. ELLIS SPIKER, 201 BOWERY ST., FROSTBURG, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, left</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>
(b) <u>Coronary Aneurysm, left</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>

<u>Years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | OCTOBER 5, 1968 | | | | | |
| | | | ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 10/8/68 | | | SUNSET MEMORIAL PARK | | | CUMBERLAND, ALLEGANY, MD. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| MARILOU M. SOWERS | | | HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG | | | DATE OCT 11 1968 | | | J Charles Judge | | |

00761

00:0 8:31, 1:00

00:0 0:01, 1:00

00:0

00:0 0:01, 1:00

00:0 0:01, 1:00

00:0 0:01, 1:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13786

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13797

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) WILLIAM Jackson STAGGS | | | 2a. DATE OF DEATH
Month OCTOBER Day 12 Year 1968 | | 2b. HOUR
6:35P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
08-26-92 | | 6. AGE (In years last birthday)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH
ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSP., CUMB. MD. Truck Foreman | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Truck Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
ALLEGANY | 13c. CITY OR TOWN
CRESAPTOWN | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER
Winchester Rd. | |
| 14. FATHER'S NAME First Middle Last
JOHN S. STAGGS | 15. MOTHER'S MAIDEN NAME First Middle Last
IDA E. DAWSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
705-10-8709 | 17. INFORMANT Address
HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 acute coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
1 year
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-15 , 19 68 , to 10-12-1968 , that (I) (we) last saw the deceased alive on 10-11 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
L. Brings | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
10-13-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
LEWIS BRINGS, M.D. | 22e. ADDRESS
57 GREENE ST., CUMBERLAND, MD. 21502 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
10/15/68 | 23c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park, | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. | | |
| 24. FUNERAL DIRECTOR
H. Wayne George | ADDRESS
GEORGES FUNERAL HOME, CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR
OCT 16 1968 | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | |

GEORGE FUNERAL HOME, CUMBERLAND, MD.

OCT 1 1958

27 GREENE ST., CUMBERLAND, MD. 21502

LEWIS BRINGS, H.D.

705-10-200

NO

HOSPITAL RECORD, 600 SECON DRIVE, CUMBERLAND, MD.

JOHN

STAGGS

100

NOV 20 1958

MARYLAND

ALLEGANY

CLEVELAND

CUMBERLAND

SACRED HEART HOSP., CUMBERLAND, MD.

RAILROAD

WEST VIRGINIA USA

ALLEGANY

WHITE

00-58-02

25

WILLIAM

JACKSON

STAGGS

OCTOBER 12

1958 0:351

18787

18787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13787

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13798

| | | | | | |
|---|--|--|--|---|---------------------------------------|
| 1. DECEASED-NAME
(Type or print) First Middle Last
HELEN D. STAIR | | | 2a. DATE OF DEATH
Month 10 Day 30 Year 68 | | 2b. HOUR P
8:24 MIN. |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
10-30-96 | |
| 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
ALLEGANY COUNTY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | |
| 13c. CITY OR TOWN
FROSTBURG | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
61 BROADWAY | |
| 14. FATHER'S NAME First Middle Last
EDWARD DUFTY | | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARY JANE DUFTY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
220-44-7447 | | 17. INFORMANT
SACRED HEART HOSPITAL-900 SETON DR., CUMB., MD. 21502 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>atherosclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>6 months</u>
<u>2 years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201 pericarditis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> , 19 <u>68</u> , to <u>10-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>L. Brings</u> | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10-31-68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
L. BRINGS M.D. | | 22e. ADDRESS
57 GREENE ST., CUMB., MD. 21502 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
11-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY
F.B.G. MEMORIAL PARK | |
| 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, ALLEGANY, MD. | | 24. FUNERAL DIRECTOR
DURST FUNERAL HOME, 57 FROST AVE., FROST., MD. | | | |
| 24a. ADDRESS
21532 | | 24b. REC'D BY REGISTRAR
NOV 4 1968 | | 24c. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

1978

1978

10 30 8:20 STAIR HETEM

10-30-26 WHITE FEMALE
ALLEGANY COUNTY U.S.A.

SACRED HEART HOSPITAL
ALLEGANY FROSTBURG X
41 BROADWAY

EDWARD DUFFY HARRY JANE DUFFY

220-11-7117 SACRED HEART HOSPITAL-POO SECTION OF...
NO

27 GREENE ST., CUM... NO. 21502 L. BRINGS I.D.

21532
DURST FUNERAL HOME, 27 FIRST AVE., FROST, MD. NOV 1 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13788

CERTIFICATE OF DEATH

13799

| | | | | | | | | | | | |
|---|--|--|--------------|--|--|---|-------------------|--|--|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First
CARL | Middle
W. | Last
TASCHENBERGER | 2a. DATE OF DEATH
Month
OCTOBER
Day
10,
Year
1968 | | 2b. HOUR
12:40 | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
FEBRUARY 8, 1904 | | 6. AGE (In years
last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
SPRING GAP, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | | 9. COUNTY OF DEATH
ALLEGANY | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
BARBER | | | 12b. KIND OF BUSINESS OR
INDUSTRY
SELF | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
OLDTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
RT. #1 | | | |
| 14. FATHER'S NAME
First
OSCAR | | Middle
W. | | Last
TASCHENBERGER | | 15. MOTHER'S MAIDEN NAME
First
EMMA | | Middle
F. | | Last
LITTLE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-05-8659 | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma colon with metastasis</u>
1538 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1538 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma colon | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-29</u> , 19 <u>68</u> , to <u>Oct. 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Carlton Brinsfield | | DEGREE | | ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-12-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. CARLTON BRINSFIELD | | 22e. ADDRESS
401 DECATUR STREET, CUMBERLAND, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/12/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Near Cumberland Alleg Md. | | | | | |
| 24. FUNERAL DIRECTOR
John J. Hafer, Jr. | | ADDRESS
230 Balto Ave., Cumberland, Md. | | 25a. REC'D BY REGISTRAR
OCT 14 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

2233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13788

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13800

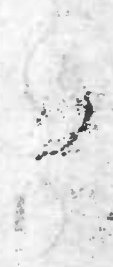
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) Ernest | | | First M | | | Middle Taylor | | | Lost | | | 2a. DATE OF DEATH
10 Month 15 Day 1968 | | | 2b. HOUR
755A | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
9-7-79 | | | 6. AGE (In years last birthday)
89 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
Mineral W. Va. | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Allegany Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cumberland Nursing Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
West Virginia | | | 13b. COUNTY
Mineral | | | 13c. CITY OR TOWN
Keyser | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Rt. 2 Box 54 | | | | | |
| 14. FATHER'S NAME
Nathaniel Taylor | | | First Middle | | | Lost | | | 15. MOTHER'S MAIDEN NAME
Annie Taylor | | | First Middle | | | Lost | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
215-36-9930 | | | 17. INFORMANT
E. H. Taylor | | | Address
RFD. #2, Keyser, W. Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute coronary occlusion
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 hour
1 year | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-10 , 19 68 , to 10-15-1968 , that (I) (we) last saw the deceased alive on 10-9- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
L. Brings | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
10-15-68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Lewis Brings | | | 22e. ADDRESS
57 Greene Street Cumberland Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Oct. 18, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cabin Rub Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Keyser, W. Va | | | | | | | | |
| 24. FUNERAL DIRECTOR
Rotruck & Chambers | | | ADDRESS
85 S. Main St. Keyser, W. Va. | | | 25a. REC'D BY REGISTRAR
DATE OCT 21 1968 | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | | | |

13800

OFFICE OF THE

13800



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13790

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13801

| | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|---|--------------------------------|-------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First
CHRISTIAN | Middle
T, | Last
TENNANT | 2a. DATE OF DEATH
OCT. 28 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCT. 30, 1886 | | 6. AGE (In years
last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
FROSTBURG | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
MINERS HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
FROSTBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
ROUTE 1 | | | |
| 14. FATHER'S NAME
First
WILLIAM | | | Middle
MEEK | | Last
MARY | | | 15. MOTHER'S MAIDEN NAME
First
MARY | | | Middle
STEWART | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
213-05-7119-B | | 17. INFORMANT
Address
GEORGE TENANT, RT.2, FROSTBURG, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Artery Occlusion.</u>
4349
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>332X</u>
(b) <u>Generalized atherosclerosis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Intestinal obstruction due to adhesions.</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
10/15/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Visceral adhesions | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/11</u> , 19 <u>68</u> , to <u>Oct 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alvin J. Walters</u> | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Oct 30, 1968</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. ALVIN J. WALTERS | | | | | | 22e. ADDRESS
48 BROADWAY, FROSTBURG, MD. | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
OCT. 31 '68 | | 23c. NAME OF CEMETERY OR CREMATORY
F.B.G. MEMORIAL PARK | | 23d. LOCATION (City or Town)
FROSTBURG, MD. | | County | | State | | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | | | 25a. REC'D BY REGISTRAR
DATE NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

13801

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|---|--|------------------|--|--|--|------------------|--|--|--|--|--|--|--|--|--|--|--|
| 13791 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 13802 | | | | | | | | | | | |
| Item #13e, Film G405 10/14/68 km | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | First Middle Last | | | | | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | |
| WILLIAM HENRY THOMAS | | | | | | | | | | | | OCTOBER 5, 1968 | | | | | | 4:03 PM | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| MALE | | | | WHITE | | | | 7-30-93 | | | | 75 YRS. | | | | MONTHS | | | | DAYS | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | Md. | | | | | | | | | | | | | | | |
| W.VA. | | | | U. S. A. | | | | | | | | ALLEGANY | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| CUMBERLAND | | | | MEMORIAL HOSPITAL | | | | RETIRED | | | | | | | | Blacksmith | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | | 13f. AVE. HOME | | | | | | | | | | | | | | | |
| MARYLAND | | | | ALLEGANY | | | | CUMBERLAND | | | | | | | | Alleg. Co. Home | | | | Potomac | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WILLIAM HENRY THOMAS | | | | | | MARY KNOTTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | WW I | | | | | | 213-18-2593 | | | | | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | | | | | 2 days | | | | | | | | | | | | | | | | | | | | | | | |
| 5400 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | (b) (Perforated) Appendicitis | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | 5 days | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5501 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/68, 1968, to 10/5, 1968, that (I) (we) last saw the deceased alive on 10/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| George M. Simons | | | | | | | | | | | | | | | | | | | | | | | | 10/7/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| DR. GEORGE M. SIMONS | | | | | | | | | | | | CUMBERLAND, MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | |
| Burial | | | | | | 10/8/68 | | | | | | Garr. Co. Mem. Gardens | | | | | | Oakland, Garr., Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| John O. Durst | | | | | | | | | | | | OCT 9 1968 | | | | | | Charles Judge | | | | | | | | | | | | | | | | | |
| John O. Durst, Oakland, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1873

1900

CERTIFICATE OF DEATH

1880

WILLIAM THOMAS

1900-01

U. S. A.

MEMORIAL HOSPITAL, RETIRED

WILLIAM THOMAS

WILLIAM THOMAS

MEMORIAL HOSPITAL, CUMBERLAND, MD.

1900-01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--------|---|------|--|---|--|--------------------------------|----------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| WILLIAM | | | HENRY | | THOMAS | | | | OCT. Month 29 Day 1968 Year | | M | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| MALE | | | WHITE | | | JAN. 14th, 1897 | | | 71 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| MARYLAND | | | U.S.A. | | | | | | ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| FROSTBURG | | | MINERS HOSPITAL | | | MINER | | | COAL | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND | | | ALLEGANY | | | FROSTBURG | | | | | ROUTE 1 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| SAMUEL | | | THOMAS | | | ELIZABETH | | | KOONTZ | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| YES | | | W.W.1 | | | 215-10-7246 | | | MRS. MARTHA THOMAS, RT.1, FROSTBURG, MD. | | | BOX 140, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> | | | | | | | | | | immediate | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4109</u> | | | | | | | | | | years | | | |
| (b) <u>Coronary Insufficiency</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) <u>Generalized Atherosclerosis</u> | | | | | | | | | | year | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| <u>Pulmonary fibrosis chronic</u> | | | | | | | | | | <u>Emphysema</u> | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>Oct 29, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| <u>Leslie R. Miles</u> | | | | | | | | | 10-1-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| LESLIE R. MILES, M. D. | | | STATE ST., LONACONING, MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | 11-1-68 | | | F.B.G. MEMORIAL PARK, | | | FROSTBURG, ALLEGANY, MD. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | | | NOV 4 1968 | | | Charles Judge | | | | |

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|-------------------|--|--|--|------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 13793 | | | | | 13804 | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| CLAUDE | | | W. | | WAGNER | OCTOBER 25, 1968 | | | 3:30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| MALE | | WHITE | | 6-1-95 | | 73 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| W. VA. | | USA | | | | ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CUMBERLAND | | | MEMORIAL HOSPITAL | | | Farmer | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD. | | | Garrett | | MC HENRY | | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| William | | | | | WAGNER | Narazzo E. | | | | | WARD |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| | | | | | | Memorial Hospital, Cumberland, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4369 C.R.A. | | | | | | | | | | 2 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | year | |
| (b) Grandeur arteriosclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1968, to Oct 25, 1968, that (I) (we) last saw the deceased alive on Oct 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. B. Schindler | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 10/28/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| DR. B. SCHINDLER | | | | | | 43 GREENE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | Oct. 28, 1968 | | Garrett Co. Memorial Gardens, Oakland | | Garrett, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home, Oakland, Maryland | | | | | | DATE NOV 12 1968 | | J Charles Judge | | | |

18804

18804

OCTOBER 22, 1968 3:30P

WASHER

W.

CLAUDE

ALLEGANY

USA

W.VA.

MEMORIAL HOSPITAL

CUMBERLAND

TO HENRY

WASHER

42 GREENE ST., CUMBERLAND, MD.

DR. B. SC. HENDER

NOV 12 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| FLORENCE VIRGINIA WHETZEL | | | | | | OCTOBER 30, 1968 | | 10:45 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| FEMALE | | WHITE | | 6-10-87 | | 81 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| W. VA. | | U.S.A. | | | | ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND | | | MEMORIAL HOSPITAL | | | Housewife | | OWN Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| W. VA. | | | Hardy | | MATHIAS | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Star Route | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| JEHRU JENKINS | | | SARAH JOHNSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 234-62-3933 B | | Mrs. Ada Dove Mathias W. Va.
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>Advanced Generalized Atherosclerosis</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 4500 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 19 <u>68</u> , to <u>10-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>William P. James</u> | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10/31/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. W.P. JAMES | | | | | 22e. ADDRESS
441 N. CENTRE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 11/2/68 | | Mathias Memorial Cemetery | | Mathias, Hardy, W. Va. | | | | |
| 24. FUNERAL DIRECTOR
H. Wayne George Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

18807

18807

FLORENCE VIRGINIA

DECEMBER 30, 1960 10:15

FEWALE

WHITE

6-10-57

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W.VA.

U.S.A.

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ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

HEARN

JENNINGS

SARAH

JOHNSON

MEMORIAL HOSPITAL, CUMBERLAND, W.V.

W. J. COBURN ST., CUMBERLAND, W.V.

DR. W. J. JAMES

W. J. COBURN ST., CUMBERLAND, W.V.

NOV 4 1968

W. J. COBURN ST., CUMBERLAND, W.V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A (H)
30M REV 1/68

13795

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13806

| | | | | | | | | | | | |
|--|--|--|--------------|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | First
JOHN | Middle
G. | Last
WILFONG | 2a. DATE OF DEATH
Month Day Year
OCTOBER 9, 1968 | | 2b. HOUR
8:40 M. | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2-1-06 | | 6. AGE (in years
last birthday)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
QUEEN CITY BREWERY | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
322 FIRST ST. | | | |
| 14. FATHER'S NAME
First Middle Last
JOHN WILFONG | | 15. MOTHER'S MAIDEN NAME
First Middle Last
ELIZABETH ARBOGAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>anotemia</u>
1701
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>dehydration and acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>carcinoma, mandible and neck pt</u> 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1961 <u>cerebral metastases</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
May 1968 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
carcinoma | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 19 <u>68</u> , to <u>Oct 9</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>Oct 8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Richard Schindler MD | | | | | 22c. DATE SIGNED
OCT 11-1968 | | 22d. PHYSICIAN'S
NAME (Type)
DR. RICHARD SCHINDLER | | | | |
| 22e. ADDRESS
CUMBERLAND, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
Oct. 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 16 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

Oct 14 1968
James E. Cooper, Jr., Cooperland, Md.
Burial Oct. 15, 1968, Sunset Memorial Park, Cooperland, Md.

COOPERLAND, MD. RICHMOND, VA. 22304

NO

GENERAL HOSPITAL, COOPERLAND, MD.
ELIZABETH
JAN. 1968
GREEN CITY, MARYLAND
U.S.A.

2-1-68
XX-23

18806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|--------------|
| <div>13796</div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) NELLIE ^{First} Theresa ^{Middle} WOLFORD ^{Last} | | | | | 2a. DATE OF DEATH
Month 10 Day 29 Year 68 ¹³⁸⁰⁷ 11:30A ^{7b. HOUR} | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
05-15-15 | | 6. AGE (In years lost birthday)
53 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS
IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY ^{Md} | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
BT 5 PERSHING DR. Bowling Greene | |
| 14. FATHER'S NAME ^{First} WILLIAM ^{Middle} P. ^{Last} POLAND | | | 15. MOTHER'S MAIDEN NAME ^{First} IDA ^{Middle} M. ^{Last} SHAWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (If or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
HOSPITAL RECORD 900 SETON DR., CUMBERLAND, ^{Address} | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
174X IMMEDIATE CAUSE (a) PULMONARY OBSTRUCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) MULTIPLE METASTASES
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF LEFT BREAST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years
4 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
170X FRACTURE LEFT FEMUR - PATHOLOGICAL | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-29-68 , 19 68 , to 10-29 , 19 68 , that (I) (we) last saw the deceased alive on 10-29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert Feddis MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-30-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT FEDDIS M.D. | | | | | 22e. ADDRESS
500 GREENE ST., CUMBERLAND, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
11/1/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cem. | | 23d. LOCATION (City or Town) (County) (State)
nr. Augusta, Hampshire W. Va. | | | |
| 24. FUNERAL DIRECTOR
GEORGES H. Wayne George ADDRESS
Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

100-10

NEELIE

WOLF

10

20 11:00

13807

Female

White

05-12-12

23

West Virginia

USA

Allegany

X

Cumberland, Md.

Sacred Heart Hospital

Hone

Allegany

Allegany Hospital

X

St. S. Kershner, Jr.

William

Poland

Ida

M

Shaver

Hospital Record 000 Section Dr., Cumberland,

Robert F. Davis M.D.

200 Greene St., Cumberland, Md.

George H. Davis

Nov 1 1961

Nov 1 1961